

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17131

CERTIFICATE OF DEATH

17122

1. PLACE OF DEATH a. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Middletown		c. LENGTH OF STAY IN 1b 15 Years		a. STATE		Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Main Street		d. STREET ADDRESS		b. COUNTY		Frederick	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First J.	Middle GUY	Last AHALT	4. DATE OF DEATH December 12, 1966	Month December	Day 12	Year 1966	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1901		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) Rural Letter Carrier		10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert M. Ahalt		14. MOTHER'S MAIDEN NAME Norma Beachley							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NO 219-46-1230		17. INFORMANT Mrs. Helen Ahalt, Middletown, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic generalized arteriosclerosis 2. yrs. (c) Hypertension & Cerebral vascular 10 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Turkenous Disease									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 1962 to _____, 1966, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.		22b. DATE SIGNED							
22a. SIGNATURE <i>D. Leavitt Price</i>		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) A. TALBOTT Price		22d. ADDRESS <i>Jefferson MD</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/66		23c. NAME OF CEMETERY OR CHAMBERY Lutheran Cemetery		23d. LOCATION (City, town or county) Middletown, Fred. Co. Md.		(State)	
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Maryland		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 16 1966	
VR A15 (4) 20M 1/65									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If Institution Residence before admission)									
Frederick MARYLAND			a. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 101									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS 122 Catoctin Avenue									
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Rosella McLeod Arnold						December	12-	19	66			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 16-1901	65 yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Admissions Director			10b. KIND OF BUSINESS OR INDUSTRY Hospital			11. BIRTHPLACE (County & State, or foreign country) Norfolk- Va.			12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME Norman McLeod			14. MOTHER'S MAIDEN NAME Annie Hoge									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) No			16. SOCIAL SECURITY NO. 201-16-1990D			17. INFORMANT Mrs. James C. Reeves-3112 Bryan Road-			Address Burtonsville-Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Generalized Carcinomatosis Carcinoma of breast (rad. mastectomy)						1963			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			DUE TO (b)	DUE TO (c)						1954		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19												
21. I certify that (I) (this hospital) attended the deceased from 1954 to 12 Dec., 1966, that (I) (we) last saw the deceased alive on 11 Dec., 1966, and that death occurred at 11:20A, from the causes and on the date stated above.												
22a. SIGNATURE Charles H. Conley, Jr.			M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 12-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr.			22d. ADDRESS Professional Bldg.- Frederick, Md. 21701									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-15-1966		23c. NAME OF CEMETERY OR CREMATORIALY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) Washington-D.C. 3201 Bladensburg Road					
24. FUNERAL DIRECTOR'S SIGNATURE M.R.Etchison & Son			ADDRESS Elwood T. Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR DEC 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

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(-3.5000) 1.0000



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

17133

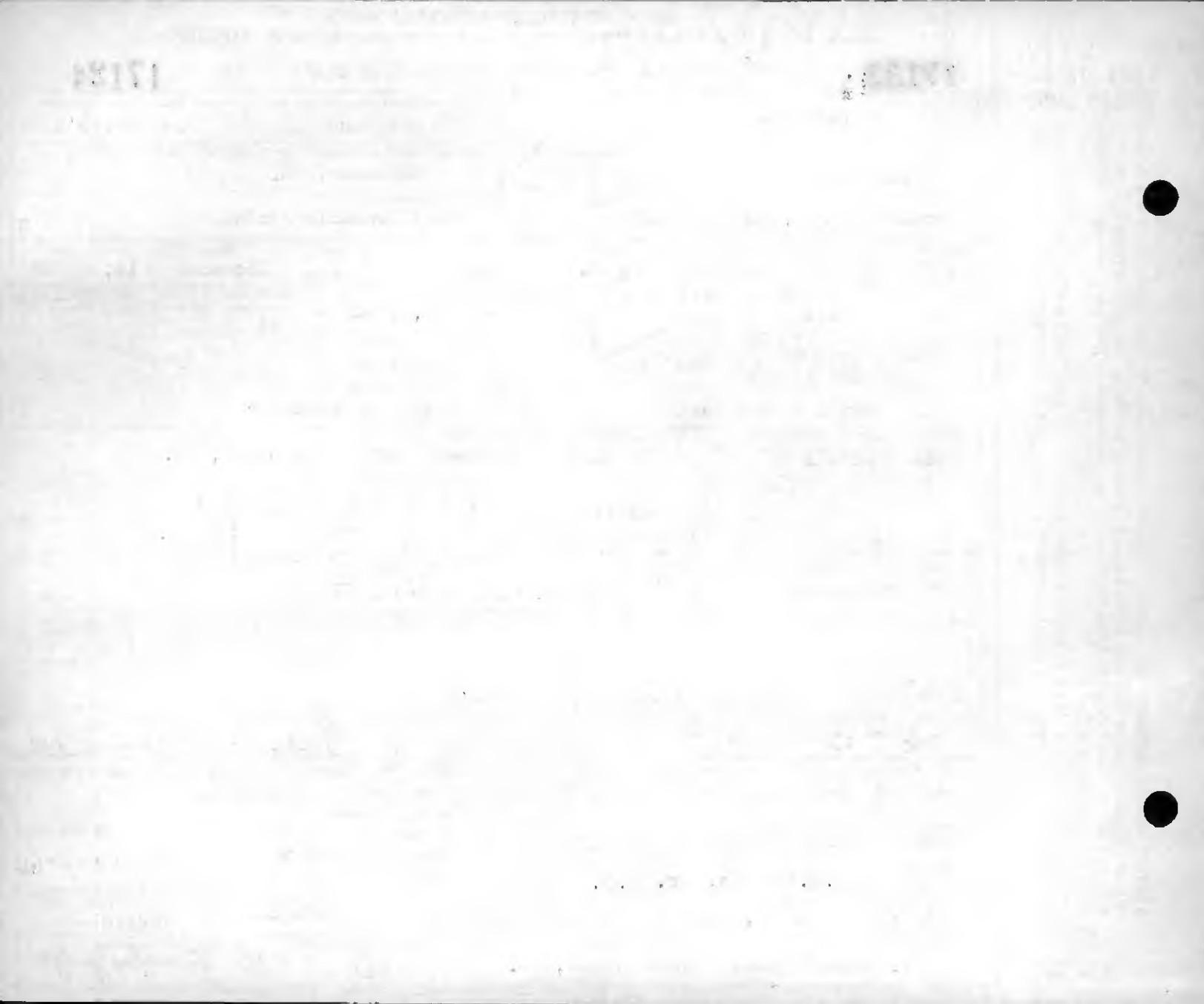
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17124

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb D O A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle M. Last Barr		4. DATE OF DEATH Month December Day 11, Year 1966	
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept 13, 1932
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY Buildings	
13. FATHER'S NAME Martin I Barr Sr		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes Korean		14. MOTHER'S MAIDEN NAME Thelma B Henderson	
16. SOCIAL SECURITY NO. 214 36 4506		17. INFORMANT Elizabeth Barr Address Seabrook, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 866X DUE TO Avulsion of Skull & Brain; Coupé Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO Fractures all extremities; Ruptures (c) DUE TO Liver & Spleen & Heart			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft crash			
20c. TIME OF INJURY Month, Day, Year Hour 3 10 p.m. 12-10 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Mountain Top
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O.Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) B.O.Thomas, Sr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 15, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
		DATE DEC 16 1966	



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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17134

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17125

I. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highway - Jefferson		c. LENGTH OF STAY IN lb —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson		d. STREET ADDRESS —		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Gilbert	Middle A.	Last Berry-Jr.	4. DATE OF DEATH December 16- 19 66	Month December	Doy 16	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Oct. 13-1934	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Hours 0	Min. 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Berryville - Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Gilbert A. Berry-Sr.				14. MOTHER'S MAIDEN NAME Marie Butler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 1963		17. INFORMANT Mrs. Louise Wright Berry-Jefferson, Md. 21755		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Asphyxia - Blood 816-4 Fractured Maxilla						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Two car collision				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour am. 5 p.m. 12-16 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Jefferson - Frederick - Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspectian <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>								
ACTUAL SIGNATURE B.O. Thomas		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-16-66		
EXAMINER'S NAME (Type) B.O. Thomas, Sr. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 20-1966		23c. NAME OF CEMETERY OR CREMATORIAL Jefferson Meth. Cemetery		23d. LOCATION (City or Town) (County) (State) Jefferson, Md. 21755		
24. FUNERAL DIRECTOR M.R. Etchison & Son		ADDRESS Frederick, Md. 21701		25a. REC'D BY REGISTRAR DATE DEC 21 1966		25b. REGISTRAR'S SIGNATURE James Judge		

1915

1915

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17135

CERTIFICATE OF DEATH

17126

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson-Rural 21755		c. LENGTH OF STAY IN 1b 90 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Near Jefferson		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson-Rural 21755	
f. STREET ADDRESS Near Jefferson		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN STEPHEN BOWLUS		4. DATE OF DEATH December 18, 1966	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6 April 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Minister of the Gospel		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Near Broad Run, Md.
13. FATHER'S NAME Franklin L. Bowlus		14. MOTHER'S MAIDEN NAME Sarah Beachley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219 05 2149	17. INFORMANT Address Miss Sarah E. Bowlus (Same as item #1)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition and Cerebral Thrombosis</i> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i> (c) <i>Advanced Arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH 2 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12/17 1966 , and that death occurred at 12:15 p. 12/18, 1966 , M, from the causes and on the date stated above.		22b. DATE SIGNED 19 Dec 1966	
22a. SIGNATURE <i>A. Talbott Brice</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. PHYSICIAN'S NAME (Type) A. Talbott Brice, M. D.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Pleasant View Cemetery
24. FUNERAL DIRECTOR <i>Frank R. Smith</i>		ADDRESS M. R. Etchison & Son, Frederick, Md. 21701	25a. REC'D BY REGISTRAR DEC 23 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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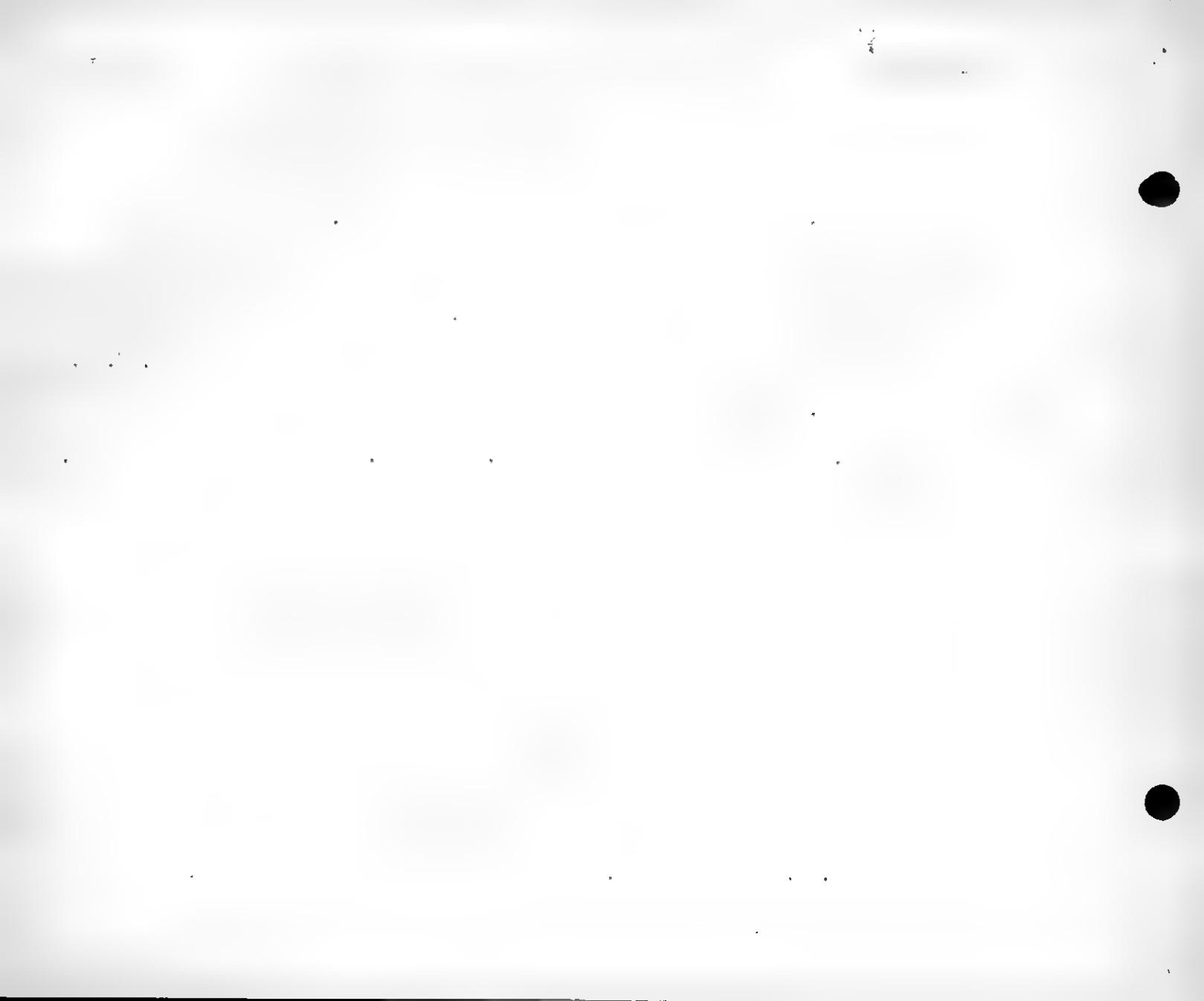
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17127

17136

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Years		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 East 11th. Street		d. STREET ADDRESS 10 East 11th. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) MARGIE		First MENN	Middle CASWELL	Last DECEMBER	4. DATE OF DEATH 4	Month December	Day 19	Year 1966				
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1900	9. AGE (in years last birthday) 66	F. UNDER 1 YEAR Months 0	I. F. UNDER 24 HRS Days 0	H. Hours 0	M. Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Adamstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME William H. Renn		14. MOTHER'S MAIDEN NAME Edith Smith		Address								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service Yes W. W. # 1		16. SOCIAL SECURITY NO 579 22 2774		17. INFORMANT Mrs. Norman F. Filliaux, Baltimore, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 42a/ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Maryland	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE B. O. Thomas		EXAMINER'S NAME (Type) B. O. Thomas, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Dec. 4, 1966				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 7, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland						
24. FUNERAL DIRECTOR Donald M. Etchison		ADDRESS ... n. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DEC 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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M

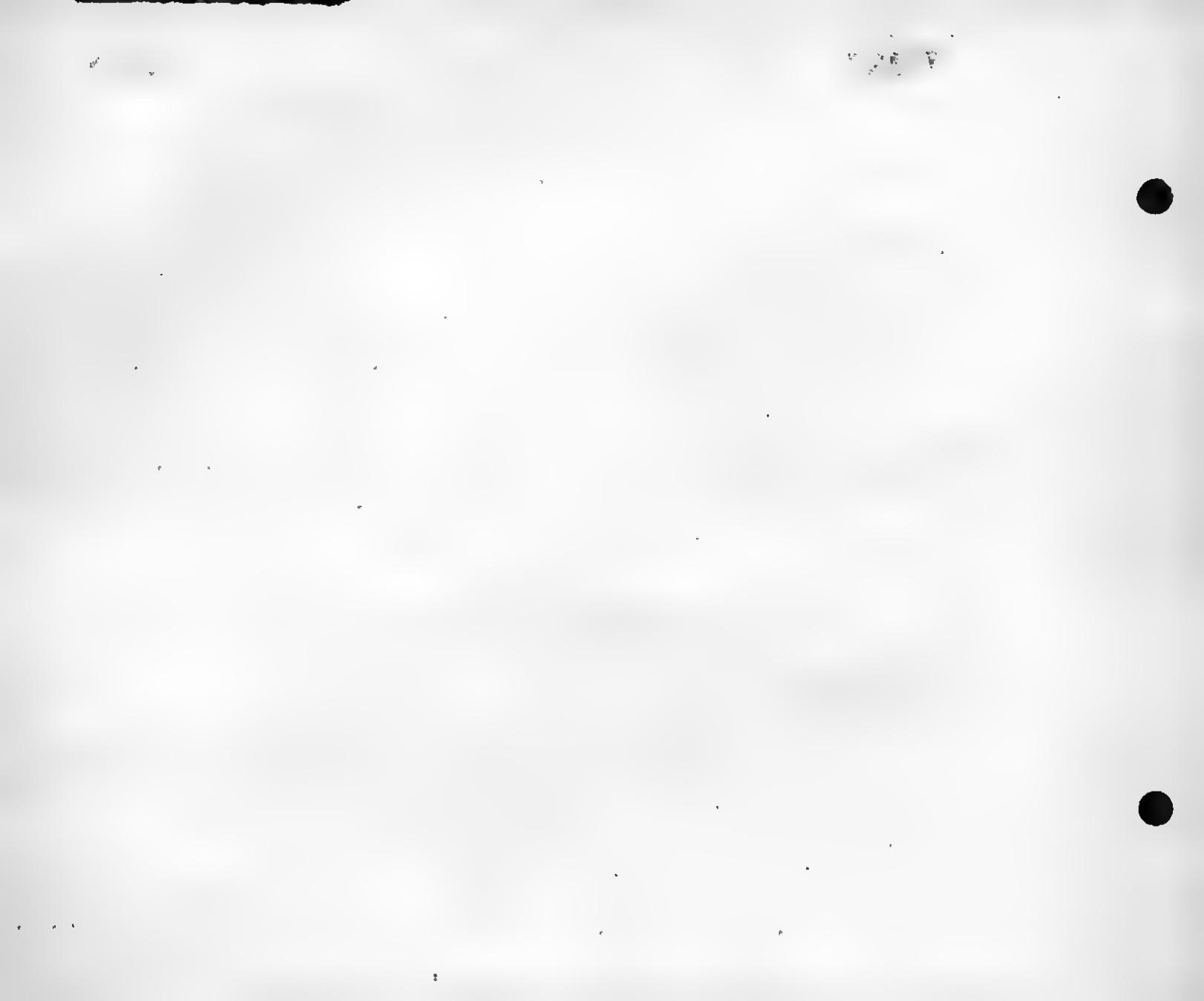
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17137

CERTIFICATE OF DEATH

17128

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Emmitsburg,		c. LENGTH OF STAY IN lb 75 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Emmitsburg
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) James Henry Cool		First James	Middle Henry
4. DATE OF DEATH December 19, 1966	Month 19	Day 19	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 9, 1883	9. AGE (in years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Adams Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel D. Cool		14. MOTHER'S MAIDEN NAME Ida J. Sanders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220-10-5787	
17. INFORMANT Mrs. Susan Cool, Fairfield, Pa. R.D. # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerotic heart disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or Town) Emmitsburg		(County) Maryland	
(State) MD		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (1) (this hospital) attended the deceased from Oct 1959 , to Dec 19, 1966 , that (2) (we) last saw the deceased alive on Dec 14, 1966 , and that death occurred at 3 P.M. from causes and on the date stated above.		22b. DATE SIGNED 12/20/66	
22a. SIGNATURE <i>George F. Moringstar</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Emmitsburg, Maryland
22c. PHYSICIAN'S NAME (Type) George F. Moringstar		23d. LOCATION (City or Town) Emmitsburg, Frederick Co. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 23, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery
24. FUNERAL DIRECTOR Clarence E. Wilson		ADDRESS Emmitsburg, Md.	25a. RECD BY REGISTRAR DEC 23 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

17138

CERTIFICATE OF DEATH

Items 23c, 23d, 25c, 25d 12/14/66 mh

17129

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Route 5 Frederick

c. LENGTH OF STAY IN lb

MARYLAND

Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Route # 5, Frederick

3. NAME OF DECEASED

(Type or print)

RALPH

First MIDDLE
EDWARD

5. SEX

Male

6. COLOR OR RACE
White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Last Month
CULLER December

Day

Year

6 1966

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Farmer

11. BIRTHPLACE (County & State, or foreign country)

Frederick County, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John J. Culler

14. MOTHER'S MAIDEN NAME

Annie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

220 30 9995 Mrs. Olive Culler (Same as item #2)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO

(b)

DUE TO

(c)

Aortic Stenosis, mitral stenosis and regurgitation - Known since 1962

Rheumatic heart disease

INTERVAL BETWEEN ONSET AND DEATH

1962

?

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1962 19, 10, 6 AM, to 1962, that (I) (we) last saw the deceased alive on 7/1/62, and that death occurred 7/1/62 AM, from the causes and on the date stated above.

22a. SIGNATURE

Charles H. Conley, Jr.

M.D.

22b. DATE SIGNED
Dec 6, 1966

22c. PHYSICIAN'S NAME (Type)

Charles H. Conley, Jr. M. D. 228 N. Market Street, Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Dec. 8, 1966

23c. NAME OF CEMETERY OR CREMATORIUM

Hrouw Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Donald M. ADDRESS

Mr. H. Hutchison & Son, Frederick, Maryland

25a. REC'D BY REGISTRAR

DEC 8 1966

DATE

25b. REGISTRAR'S SIGNATURE

James Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17139

CERTIFICATE OF DEATH

17130

Item 14 17139 17130

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

24 West 12th Street

**3. NAME OF DECEASED
(Type or print)**

First
JOSEPH

Middle
WILLIAM

Last
DARNER

4. DATE OF DEATH Month Day December 29, 1966

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED **NEVER MARRIED**

WIDOWED DIVORCED

B. DATE OF BIRTH

Jan. 19, 1876

9. AGE (In years last birthday)

90 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farming

11. BIRTHPLACE (County & State, or foreign country)

Frederick County, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Robert Darner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service

No

16. SOCIAL SECURITY NO.

213-48-8743 Miss Alice Darner

24 W. 12th St. Frederick, Md. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

191.4

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Sinility with arteriosclerotic heart disease

skin cancer

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

2-3 yrs

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from June 1966, to Dec. 29, 1966, that (I) (we) last saw the deceased alive on Dec. 1, 1966, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Dr. Rex R. Martin

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

DATE SIGNED
12-29-1966

22c. PHYSICIAN'S NAME (Type)

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

DATE SIGNED
12-29-1966

22d. ADDRESS

22d. ADDRESS
220 North Market Street Frederick, Md.

Burial Removal (Specify)

Burial

12-31-1966,

23c. NAME OF CEMETERY OR CREMATORIAL

Reformed Cemetery

23d. LOCATION (City, town or county)

Jefferson, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Robert E. Bailey & Son

ADDRESS

Frederick, Maryland

25a. REC'D BY REGISTRAR

JAN 3

25b. REGISTRAR'S SIGNATURE

1967



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17140

CERTIFICATE OF DEATH

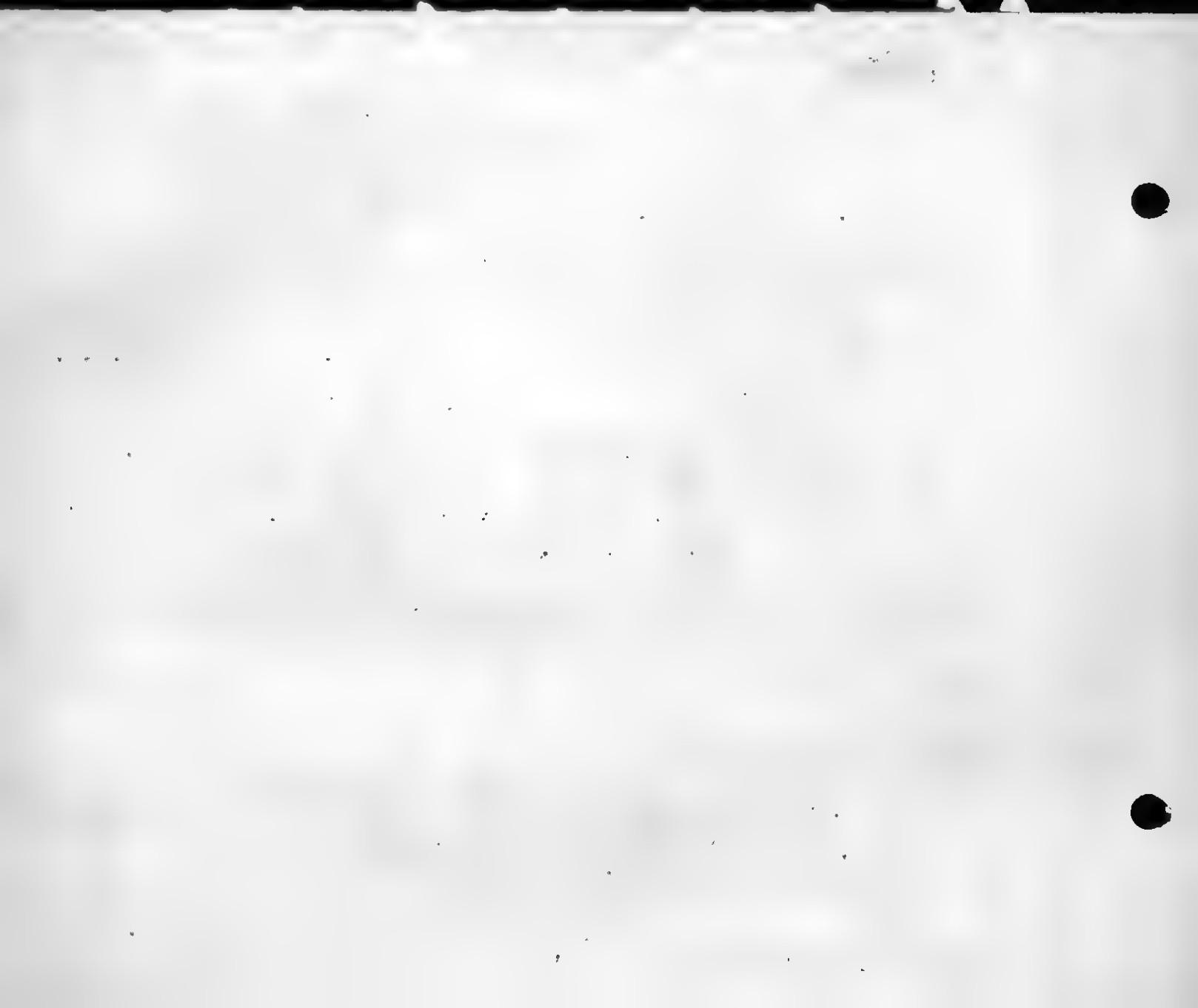
17151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 123 N. Virginia Ave.		e. STREET ADDRESS same	
3. NAME OF DECEASED (Type or print) SARAH First MARGARET Middle DEVINE		4. DATE OF DEATH Month 12 Day 9 Year 66	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 97 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Loudoun Co. Virginia	
13. FATHER'S NAME William Benjamin Mock		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No) No		16. SOCIAL SECURITY NO. 213-18-8631	
17. INFORMANT Edith Alger		Address Brunswick Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Convalescent</i> (c) DUE TO <i>Attended the house down</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Convalescent bottom</i>			
INTERVAL BETWEEN ONSET AND DEATH — 11 yr. life.			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (This Hospital) attended the deceased from 11-1-1966 to 12-9-1966, that (I) (we) last saw the deceased alive on 12-9-1966, and that death occurred at 12 P.M. from the causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 12-10-66	
22c. PHYSICIAN'S NAME (Type) C.E. Pruitt M.D.		22d. ADDRESS Brunswick Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/II/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Park Heights Cemetery Brunswick Md.		23d. LOCATION (City, town or county) (State)	
24a. FUNERAL DIRECTOR <i>Tate Funeral Home</i>		25a. REC'D BY REGISTRAR	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17141

CERTIFICATE OF DEATH

17132

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 5 Yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 42 East Patrick Street		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Vindobona Convalescent & Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EMMA NEWMAN		First EMMA	Middle NEWMAN	Last ENGLAND	4. DATE OF DEATH December 31, 1966	Month December	Day 31	Year 1966
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Jan 1877	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Woodsboro, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Jacob M. Newman				14. MOTHER'S MAIDEN NAME Katherine Shaw				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-38-9104		17. INFORMANT Parsons Newman, Frederick, Md.		Address 303 Upper College Terrace, Frederick, Md. 21701		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH About 5 years								
532X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (Sen Ctg) (c) Dematuria - Cancer lung & liver								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dematuria - Cancer lung & liver								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 15, 1966, to Dec. 31, 1966 , that (I) (we) last saw the deceased alive on Dec. 31, 1966 , and that death occurred at 3 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 12/31/66						
22a. SIGNATURE C. A. Pearre, Sr.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) A. A. Pearre, Sr.		22d. ADDRESS 4 E. Church St., Frederick, Md. 21701						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/67		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701		
24. FUNERAL DIRECTOR Frank B. Smith		ADDRESS M. R. Etchison & Son, Frederick, Md. 21701		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 20M 1/65				DATE JAN 3 1967				



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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

17142

CERTIFICATE OF DEATH

17133

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		Item 8 <i>same as 9003</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE		Maryland		b. COUNTY	
Frederick		3 weeks		Frederick		Frederick		C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Frederick Nursing Home		d. STREET ADDRESS		Middletown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
male		George	Glenn	Gladhill	12	2	19	66	
6. COLOR OR RACE		7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
white		WIDOWED	DIVORCED	8/2/66 1900	66 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
furniture salesman		retail		Frederick Co., Md.		U.S.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address					
Calvin T. K. Gladhill		Lola Mae Wiles		Kenneth A. Gladhill, Middletown, Md.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
no		213-01-5472		Kenneth A. Gladhill, Middletown, Md.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4</i>		<i>Chronic Congestive Failure</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <i>and (c)</i>		20d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20e. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <i>Gout</i>		6 yrs.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Middletown		(County) (State)	
19									
21. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 19 <i>66</i> , to <i>12/2</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/11</i> , 19 <i>66</i> , and that death occurred at <i>7A</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>Charles H. Conley, Jr.</i>		22b. DATE SIGNED <i>2 DEC 1966</i>					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>CHARLES H. CONLEY, JR. FREDERICK, MARYLAND</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
burial		12/4/66		Lutheran Cemetery		Middletown, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		Gladhill Company, Middletown, Md.		REC'D 12/4/66		1900		<i>judge</i>	
20M 1/65				DATE					

1



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17143

CERTIFICATE OF DEATH

17134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz		c. LENGTH OF STAY IN 1b Lifetime		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz		
3. NAME OF DECEASED (Type or print) Frederick Lee Green		First Frederick	Middle Lee	
4. DATE OF DEATH Dec. 23		Last Green	Month Dec. Day 23 Year 1966	
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	
8. OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		9. DATE OF BIRTH May 25, 1915		
10. KIND OF BUSINESS OR INDUSTRY Construction		9. AGE (In years at birthday) 51 yrs		
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Rex Green		14. MOTHER'S MAIDEN NAME Violet Wolf		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO 216-03-7588		
17. INFORMANT Helen L. Green		Address Lantz, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction.		INTERVAL BETWEEN ONSET AND DEATH 5-10 minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ (c) _____		DUE TO DUE TO DUE TO		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Foxville (County) Fred. Co. (State) Md.
21. I certify that (I) (this hospital) attended the deceased from 2-27 , 1954, to 23 Dec. , 1966, that (I) (we) last saw the deceased alive on Oct. 24 , 1966, and that death occurred at 2 PM , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE Harry H. Youngs		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12-23-66
22c. PHYSICIAN'S NAME (Type) Harry H. Youngs		22d. ADDRESS Blue Ridge Summit, Pa.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-26-66	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Bethel Meth. Cem.	23d. LOCATION (City or Town) Foxville (County) Fred. Co. (State) Md.
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont,	25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17144

CERTIFICATE OF DEATH

17135

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Frederick

MARYLAND

c. LENGTH OF STAY IN b

years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

24 Winchester Street

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Elmer

Lester

Hargett

24 Winchester Street

Month

Day

December 6- 1966

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

March 6- 1885

9. AGE (In years
last birthday)

81 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Contractor

10b. KIND OF BUSINESS OR INDUSTRY

House Construction

11. BIRTHPLACE (County & State, or foreign country)

Frederick Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Simeon Hargett

14. MOTHER'S MAIDEN NAME

Mahalia Griffith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give era and dates of service)

No

16. SOCIAL SECURITY NO.

214-10-3568A

17. INFORMANT

Address Frederick, Md.

Mrs. Minnie E. Smith Hargett-24 Winchester St.

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Cerebral Arteriosclerosis.

INTERVAL BETWEEN
ONSET AND DEATH

2 years.

334X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first
(b)
DUE TO _____
(c)
DUE TO _____
DUE TO _____

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
White Not White
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from January, 1966, to Dec. 4, 1966, that (I) (we) last
saw the deceased alive on Dec. 4, 1966, and that death occurred at 12:05A.M. from the causes and on the date stated above.

22e. SIGNATURE

W.H. Riddick

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

Dec. 6-1966
22b. DATE SIGNED

22c. PHYSICIAN'S
NAME (Type)

Dr. Willis J. Riddick

22d. ADDRESS

Frederick Medical Center-Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Dec. 8-1966

23c. NAME OF CEMETERY OR CREMATORIUM

Mt. Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Md. 21701

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Elwood M.R. Etchison & Son

ADDRESS T. Whitmore

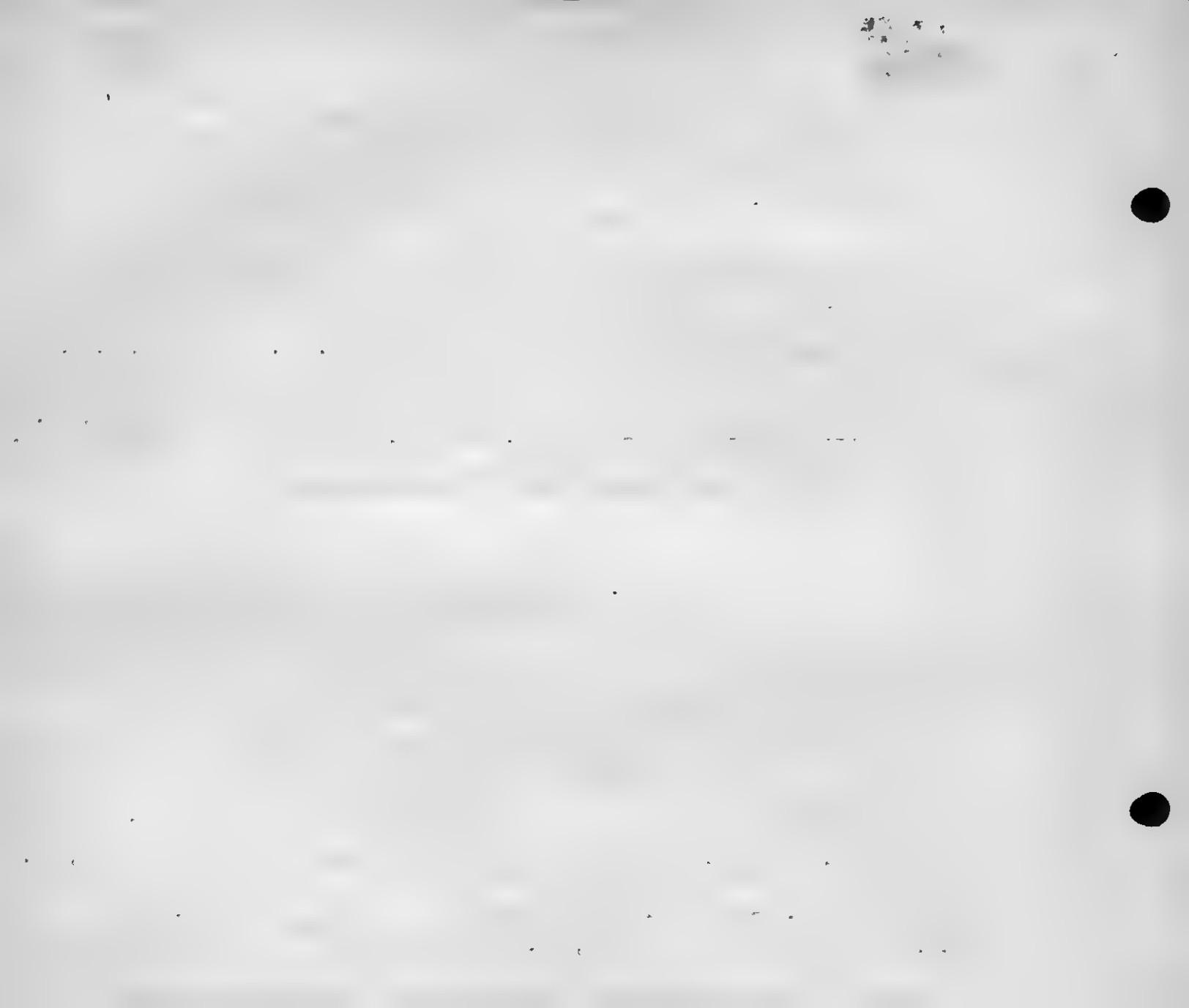
Frederick, Md. 21701

25a. REC'D BY REGISTRAR

DEC 9 1966

25b. REGISTRAR'S SIGNATURE

J. Charles Judge



FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17145

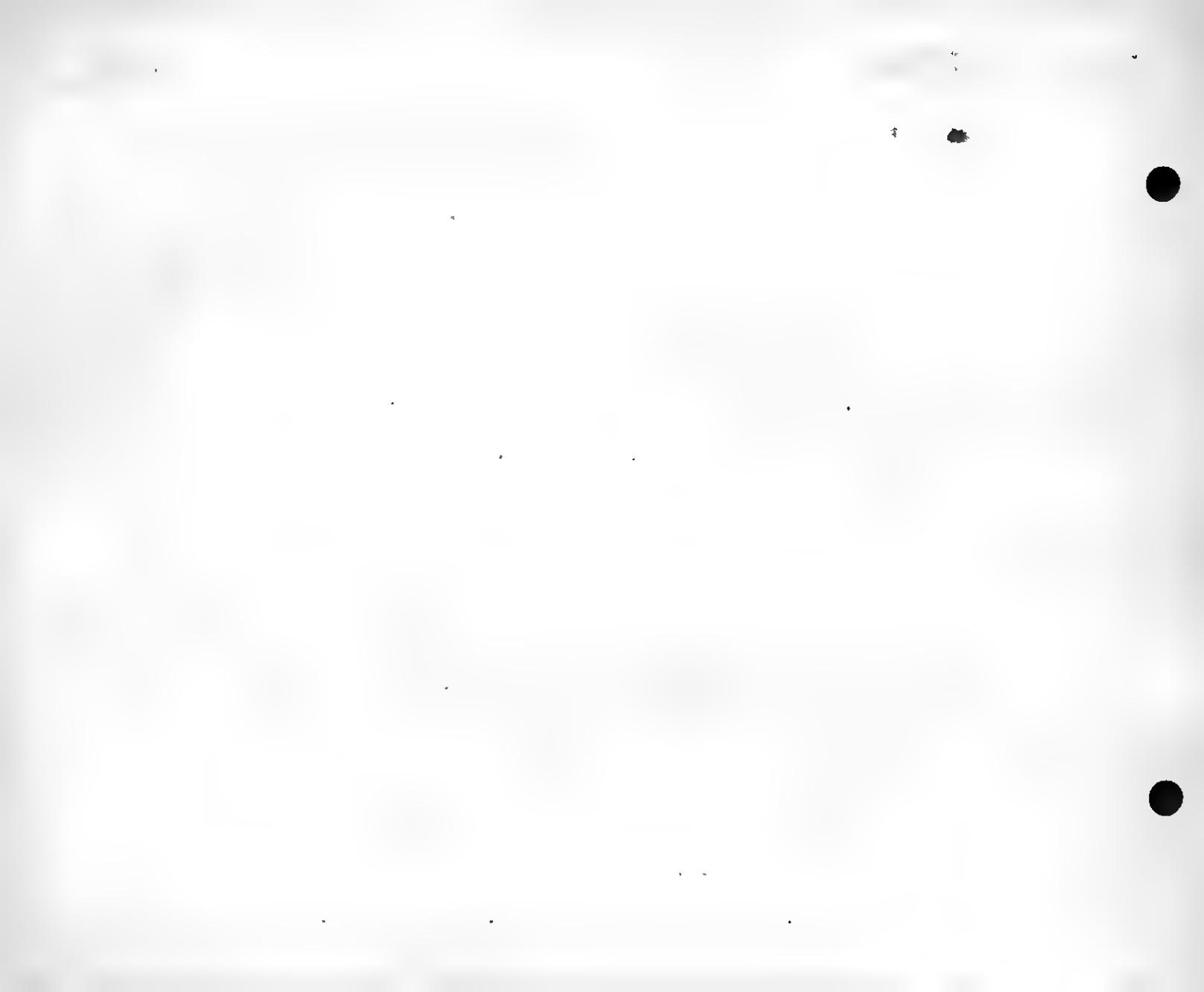
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17136

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Hours		d. CITY DR TOWN (if outside corporate limits write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rear 602 Trail Avenue			e. STREET ADDRESS Apt. #5, John Hanson		
3 NAME OF DECEASED (Type or print) Sandra Lee Harley			4 DATE OF DEATH December 15- 19 66		
5 SEX Female White		6 COLOR OR RACE WIDOWED		7 MARRIED NEVER MARRIED <input checked="" type="checkbox"/>	
8 DATE OF BIRTH Nov. 13, 1952		9 AGE (In years at birthday) 14 yrs		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY High School		
11 BIRTHPLACE (State or foreign country) Frederick, Maryland			12 CITIZEN OF WHAT COUNTRY? U. S. A.		
13 FATHER'S NAME Paul G. Harley			14 MOTHER'S MAIDEN NAME Alice Martin		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16 SOCIAL SECURITY NO None		17 INFORMANT Mr. Paul G. Harley (Same as item # 2)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 891.6 Carbon monoxide poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carbon monoxide poisoning - In close garage					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Garage was filled with carbon monoxide fumes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 12 15 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Garage	
20f. (City or town) Frederick, Frederick Md		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B.O.Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-15-1966	
EXAMINER'S NAME (Type) B.O.Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county)					
23a. BURIAL, Cremation, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 18, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Resthaven Mem. Gardens, Mr. Hansonville, Maryland	
23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <i>Donald M. Federley</i>		ADDRESS Federley		25a. REC'D BY REGISTRAR DEC 19 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

17146

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17137

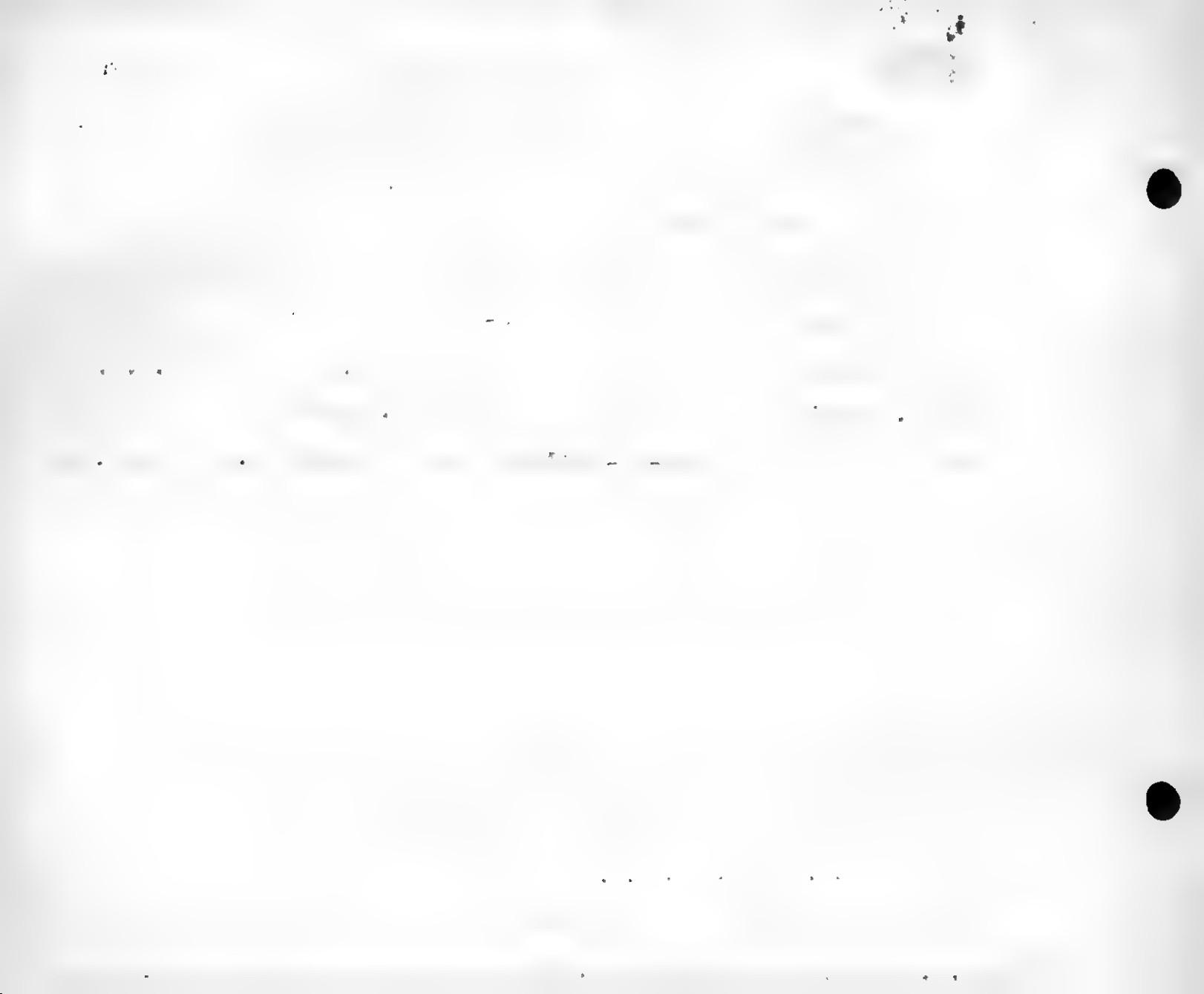
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in ~~Death~~ Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

2

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Reside before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt 26 Liberty		c. LENGTH OF STAY IN 1b minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Airy		d. STREET ADDRESS Rt 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt 26 Nr Liberytown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harold	Middle Martin	Last Harris	4. DATE OF DEATH December 4 1966	Month December	Day 4	Year 1966
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-1943	9. AGE (in years lost birthday) 23 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Construction labor		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl C. Harris		14. MOTHER'S MAIDEN NAME Anne L. Ambush		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-42-1667		17. INFORMANT Mrs Anna L Harris Rt.4 Mt Airy, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 8.25.4 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		Acute Congestive Heart Failure Massive Hemorrhage Rupture & Liver & Spleen				INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Auto accident		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) Highway		20d. (City or town) Liberty - Frederick - Md.	
20e. TIME OF INJURY Month, Day, Year Hour 7:40 pm 12-4-66		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20g. (County) Frederick		(State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B.O.Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-4-66	
EXAMINER'S NAME (Type) B.O.Thomas, Sr. M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) St Pauls Church			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/8/66	23c. NAME OF CEMETERY OR CREMATORIUM St Pauls Church	23d. LOCATION (City or Town) Frederick County	(County) Frederick County	(State) Md.		
24. FUNERAL DIRECTOR C.E. Hicks, III	ADDRESS Frederick, Md	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE				
VR ATSM (5) 6M 1/66		DATE DEC 8 1966					



Items 13&21 Film 383 12-13 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE
HEALTH DEPT.

47147

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17138

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm files. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Frederick		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Airy		c. LENGTH OF STAY IN 16 22 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 4		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Airy	
f. STREET ADDRESS R.D. 4		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First JOHN	Middle D.	Last HARRIS
4. DATE OF DEATH	Month Dec. 4,	Day 19	Year 66
5 SEX Male	6 COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8 DATE OF BIRTH Jan. 24, 1909	9 AGE (In years from birthday) 57 yrs	10a. US-A OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) Carroll Co., Md.	12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John T. Harris	14. MOTHER'S MAIDEN NAME Jennie Wimert		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes	16 SOCIAL SECURITY NO WW 2	17 INFORMANT George Miller	Address R.D. Mt. Airy, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>3220</u> <u>Differential freezing results in</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute congestive heart failure</u> (c) <u>autopsy</u> <u>Exposure to freezing temperature</u>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O.Thomas</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 12-5-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/1966	23c. NAME OF CEMETERY OR CREMATORIAL Leisters Cemetery
23d. LOCATION (City or Town) Carroll Co., Md.			
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		25a. ADDRESS C. M. Waltz Box 241 Sykesville, Md.	25b. REGISTRATION NUMBER DEC 9 1966
25c. DATE DATE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17148

CERTIFICATE OF DEATH

17139

1. PLACE OF DEATH a. COUNTY Frederick		Item 14 Film C384 17148-2 mb		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		d. STREET ADDRESS 536 West Potomac Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Wilbur		First	Middle	Last	4. DATE OF DEATH HARRISON	Month DEC	Day 21	Year 1966
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 18 1895		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machinist		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Harrison		14. MOTHER'S MAIDEN NAME Louisa Mills						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-10-2735		17. INFORMANT Virgie B. Harrison		Address Brunswick Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lung cancer</i> <i>traveled - pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH 11 Dec 1966 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 15 Dec 1966 (b) <i>Chronic emphysema</i> (c) <i>Deconditioning</i> 1748								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>16 DEC</u> , 19 <u>66</u> , to <u>21 DEC</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>21 DEC</u> , 19 <u>66</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.								
22a. SIGNATURE <i>Charles H. Conley Jr.</i>		M.O. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>21 Dec 1966</u>		
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr. M.D.		22d. ADDRESS Frederick, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Lutheran Cemetery Brunswick Maryland		23d. LOCATION (City, town or county) (State) Middletown Maryland		
24a. FUNERAL DIRECTOR Teele Funeral Home						25a. REC'D BY REGISTRAR DEC 27 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

24

25

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17149

CERTIFICATE OF DEATH

17149

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Braddock Heights

MARYLAND

c. LENGTH OF STAY IN 1B

Months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Vindabona Convalescent & Rest Home

3. NAME OF

DECEASED

(Type or print)

First

Middle

A.

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Last

Hemp

Month

December

Day

31

Year

1966

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Petersville, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Peter S. Hemp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

213 24 9309 Mrs. Mary Motherway, Route #1, Jefferson, Md.

18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

337A

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Somnolity with generalized cerebral arterosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
White Not White
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from....., 1956, to....., 1966, that (I) (we) last

saw the deceased alive on....., 1966, and that death occurred at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Rex R. Martin

Rex R. Martin, M. D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
December 31, 1966

22d. ADDRESS

22e. LOCATION (City, town or county)
Frederick, Maryland

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF
Jan. 5, 1967 Mount Olivet Cemetery

23c. NAME OF CEMETERY OR CREMATORIUM

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Ronald W. Etchison

Etchison

M. R. Etchison & Son

Frederick, Maryland

25e. REC'D BY REGISTRAR

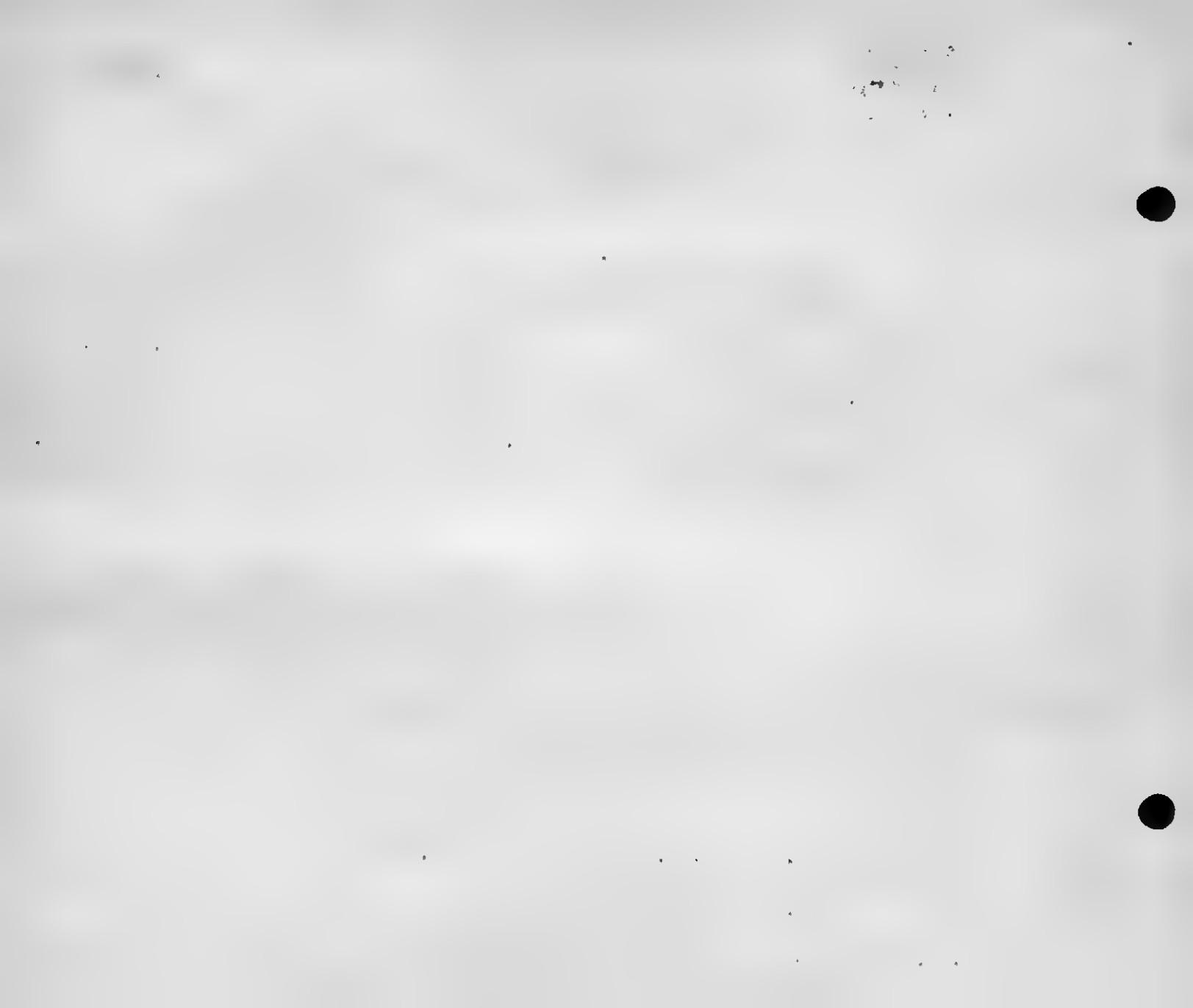
JAN 5

1967

Charles Judge

Signature

Date



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17150

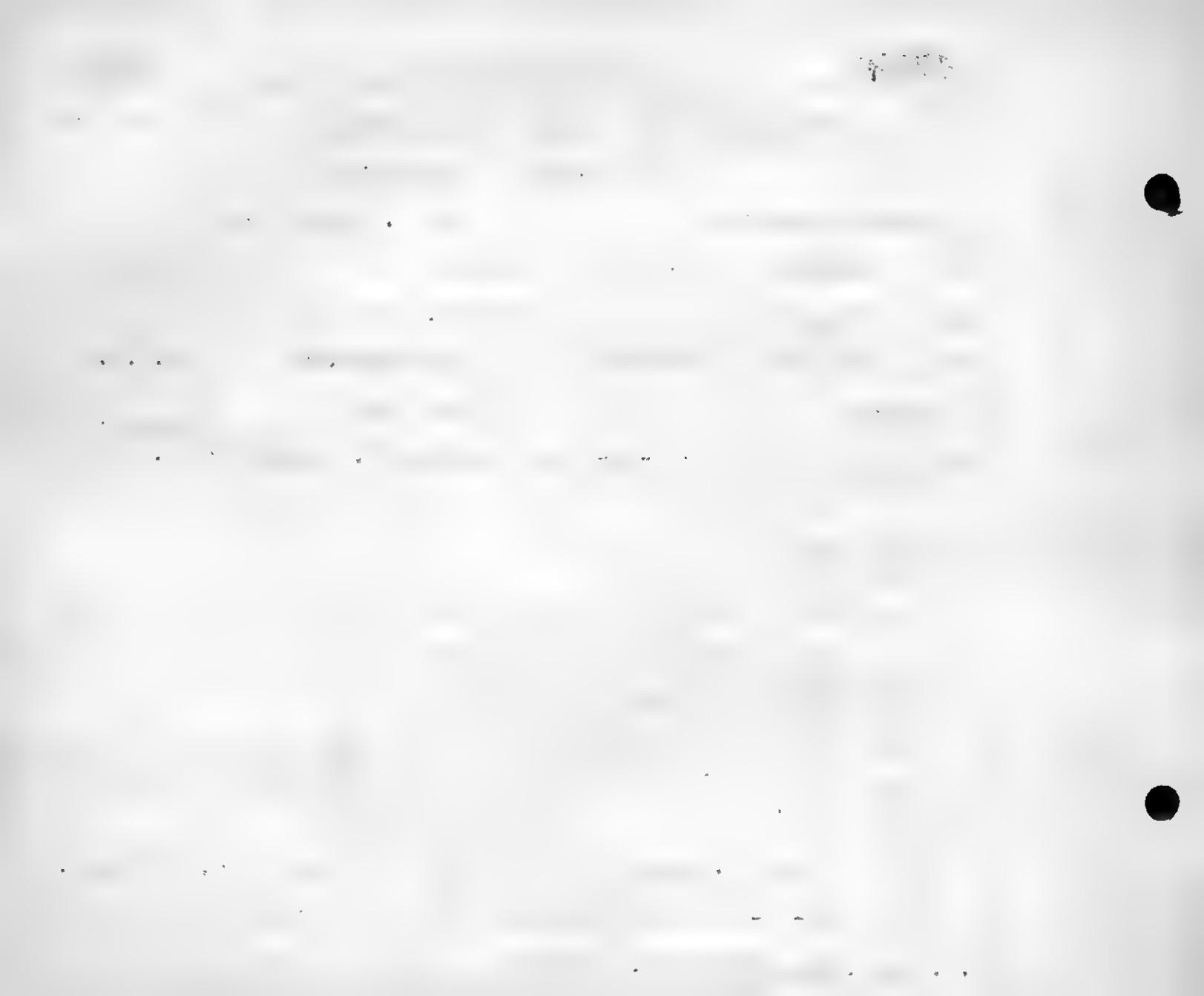
CERTIFICATE OF DEATH

17141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN b. 28 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial			d. STREET ADDRESS 127 S. Bentz Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Charles	Middle Edward	Last Henson	4. DATE OF DEATH Month Day Year December 28 1966
S SEX Male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 25, 1906	9. AGE (in years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Principal		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State or foreign country) Baltimore, Md	
13. FATHER'S NAME Eli Henson		14. MOTHER'S MAIDEN NAME Lula Hicks		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 213-14-6092		17. INFORMANT Address Gwendolyn B. Henson 127 S. Bentz St Frederick, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<i>Ruptured Intestinal Saccule Artery Anemone</i>		INTERVAL BETWEEN ONSET AND DEATH hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 127 Bentz Street	(County) (State) Frederick, Md
21. I certify that (I) (this hospital) attended the deceased from 12/18/66 , 1966, to 12/18/66 , 1966, that (I) (we) last saw the deceased alive on 12/18/66 , 1966, and that death occurred at 12/18/66 , 1966, M, from causes and on the date stated above.					
22a. SIGNATURE <i>Robert J. Thomas MD</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	M.D. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/18/66
22c. PHYSICIAN'S NAME (Type) Robert J. Thomas		22d. ADDRESS 812 Toll House Ave, Frederick, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-31-1966	23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Memorial Pk	23d. LOCATION (City or Town) Baltimore	(County) (State) Baltimore Md
24. FUNERAL DIRECTOR C.E. Hicks, III		ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR Charles J. Judge	25b. REGISTRAR'S SIGNATURE J. Charles J. Judge
20 M 1/66		DATE JAN 3 1967			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mt. Airy		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mt. Airy		d. STREET ADDRESS R.F.D. # 4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. # 4				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Bernard	Middle Washington	Last Howell	4. DATE OF DEATH Dec. 13 1966	Month	Day	Year		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1907	9. AGE (In years last birthday) yrs 59	F. UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charlestown, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph William Howell				14. MOTHER'S MAIDEN NAME Dora Louise Hoff					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-18-8906		17. INFORMANT Mrs Thelma C. Howell, Item 2		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE B.O. Thomas		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12/13/66	
EXAMINER'S NAME (Type) B.O. Thomas MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 16, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS		25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17152

CERTIFICATE OF DEATH

17143

1. PLACE OF DEATH
a. COUNTY

Frederick

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural - Frederick

c. LENGTH OF STAY IN HB

MARYLAND

Month

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Montevue Infirmary

3. NAME OF
DECEASED
(Type or print)

First

Middle

Jackson

5. SEX

Ethel

May

Female

White

WIDOWED

DIVORCED

4. DATE
OF
DEATH

December 31-

19 66

10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Indiana

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George Barber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or defense service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address Takoma Park, Md.

Mrs. Hilda Benton, 6616 Alleghany Ave,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

153.8

DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Metastasis adenocarcinoma of colon

Adenocarcinoma of colon

INTERVAL BETWEEN
ONSET AND DEATH

1 year

6 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
--	--	--	---	---	---

21. I certify that (I) (this hospital) attended the deceased from Aug. 9, 1966, to Dec. 31, 1966, that (I) (we) last saw the deceased alive on Dec. 31, 1966, and that death occurred at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE

LeRoy T. Davis

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED
12/3/66

22c. PHYSICIAN'S NAME (Type)

LeRoy T. Davis, M.D.

22d. ADDRESS
228 N. Market Street, Frederick, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF
Jan. 4, 1967

23c. NAME OF CEMETERY OR CREMATORIALy

Mount Olivet Cemetery

Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Donald M. Fodley

ADDRESS

M.R. Etchison & Son

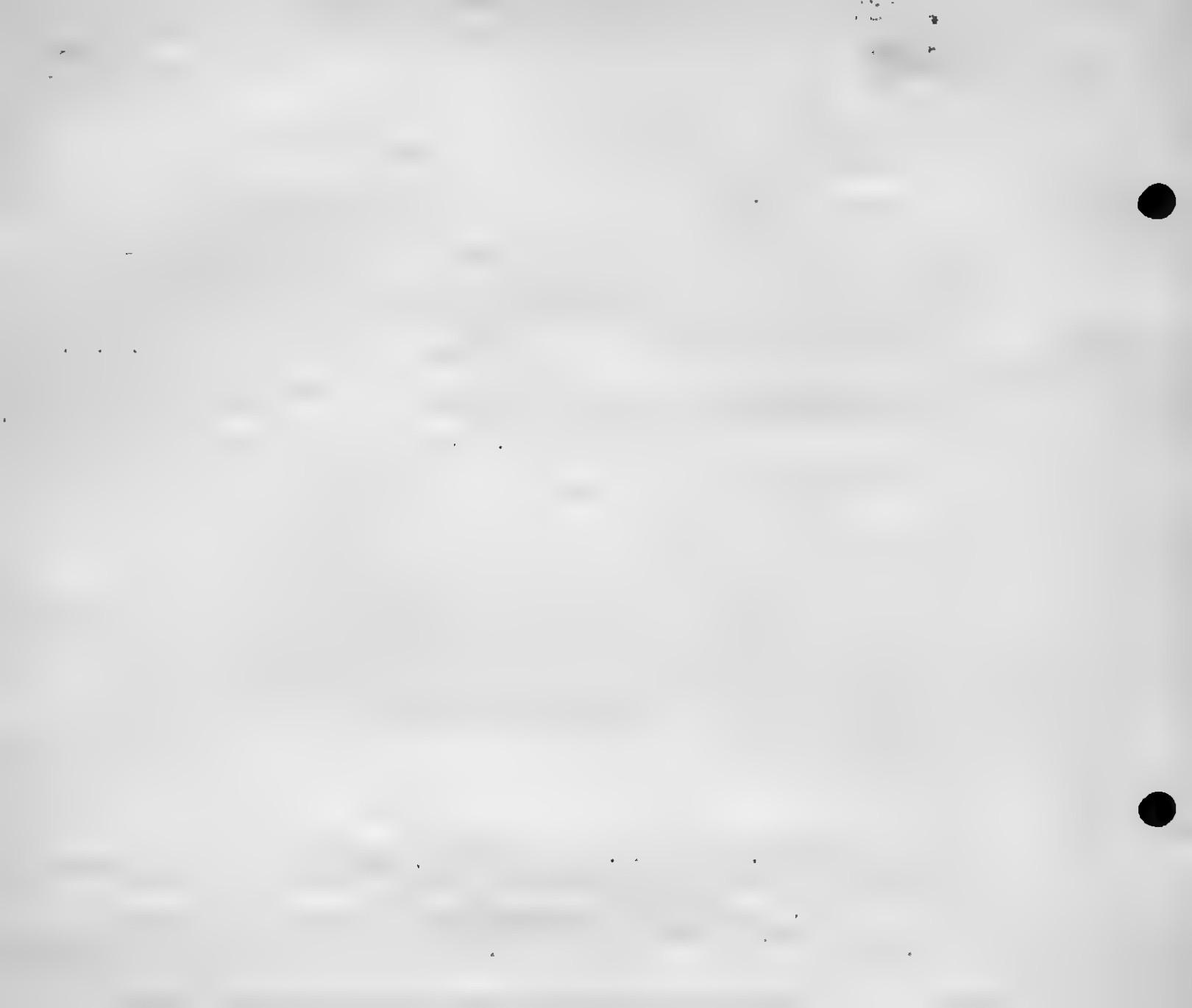
Frederick, Md. 21701

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

J. Charles Judge

DATE JAN 5 1967



FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
17153						17144					
1. PLACE OF DEATH e. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		c. LENGTH OF STAY IN 1b		a. STATE Maryland		b. COUNTY Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Frederick Memorial Hospital		1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Lewistown			
3. NAME OF DECEASED (Type or print)		First Mary O. Kanode		Middle		4. DATE OF DEATH		Month Dec. 25,		Day 19 Year 66	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
female		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 10, 1877		89 yrs.		Months Deyys Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Housewife				Own Home				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Eli Rice				Rosanna Rodgers				USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				220-52-2193				Arnold Kanode			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				Address				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i>											
450.0				DUE TO (b) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Fell at home</i>				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
19								(City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>James B. Thomas</i>											
EXAMINER'S NAME (Type) James B. Thomas											
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county)											
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)			
Burial		12-28-66		Lewistown Cemetery		Lewistown Fred Co. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Raymond E. Greager		Thurmont, Md.		REC'D N. 1000		Greager					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

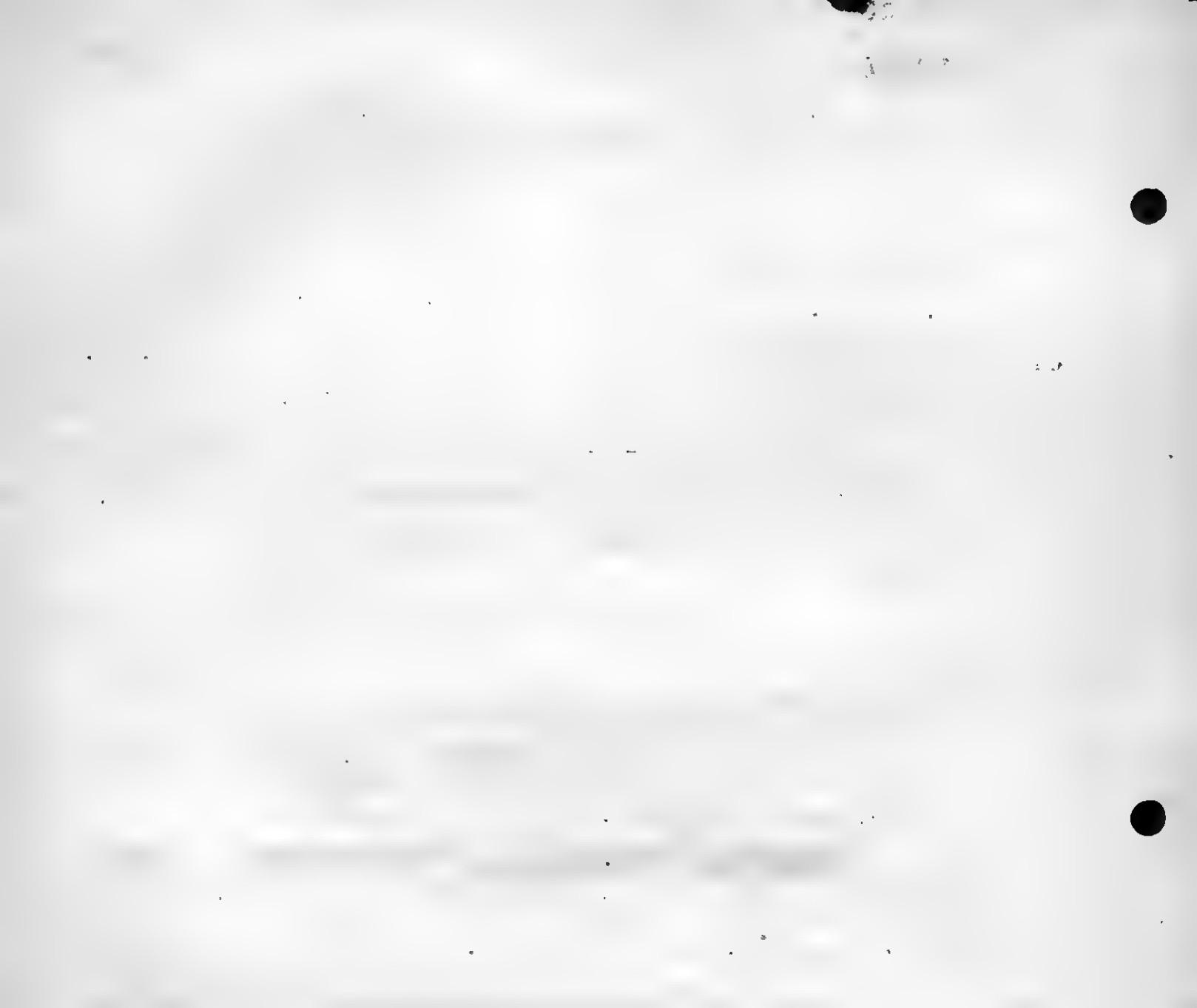
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17154

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17145

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue Infirmary				d. STREET ADDRESS 311 Brunswick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FLORENCE	Middle REBECCA	Last KIDD	4. DATE OF DEATH Month 12	Month Day	Day 3	Year 1966
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1880	9. AGE (In years last birthday) 86 yrs.	10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. Months 0	Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Fout				14. MOTHER'S MAIDEN NAME Margaret Mahoney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		212-50-8683		Gale Whitcomb		Rockville Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive Thrombosis INTERVAL BETWEEN ONSET AND DEATH 10 minutes Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic C.V.D. 10 years (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1966 to Dec 3, 1966 , that (I) (we) last saw the deceased alive on Dec 3, 1966 , and that death occurred at 11/13/66 M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Bernard O. Thomas Jr.</i>		22b. DATE SIGNED 1966					
22c. PHYSICIAN'S NAME (Type) BERNARD O. THOMAS, JR., FREDERICK MD.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Mount Olivet Cemetery		23b. DATE THEREOF 12/6/66		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City, town or county) Frederick Maryland	
24. FUNERAL DIRECTOR Forte Funeral Home		ADDRESS Brunswick, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20M 1/65				DATE DEC 8 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17155

17146

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN IB years		a. STATE Maryland	b. COUNTY Frederick
Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Frederick Nursing Center		Frederick	
e. STREET ADDRESS		704 Motter Avenue		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Daisy Evelyn			Kline	December 10	19 66
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR 87 yrs. Months Days Hours Min.
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 11- 1878	12. CITIZEN OF WHAT COUNTRY U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
House Work		Own Home		14. MOTHER'S MAIDEN NAME Margaret Mohler	
13. FATHER'S NAME Dr. Ephriam H. Kline		16. SOCIAL SECURITY NO. 17. INFORMANT 220 44 5215 Mrs. Pauline E. Nogle 117 E. 7th. St.-		Address Frederick- Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) No		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)		Cerebral vascular accident		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	Arteriosclerotic vascular disease	8 years	
DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Carcinoma of the gall bladder					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that (I) (this hospital) attended the deceased from July 19, 1966 to Dec. 10, 1966, that (I) (we) last saw the deceased alive on Dec. 10, 1966, and that death occurred at 8 P.M., from the causes and on the date stated above.	
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
22a. SIGNATURE B.O.Thomas Jr.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Dr. B.O.Thomas, Jr.		22d. ADDRESS Professional Bldg.- Frederick, Md. 21701		22b. DATE SIGNED Dec. 10-1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 14-1966	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	23d. LOCATION (City, town or county) Frederick, Md. 21701 (State)	
24 FUNERAL DIRECTOR'S SIGNATURE M.R.Etchison & Son		ADDRESS Frederick, Md. 21701	25a. REC'D BY REGISTRAR DATE DEC 13 1966	25b. REGISTRAR'S SIGNATURE j Charles Judge	
VR A15 (4) 2DM 5-63					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17156

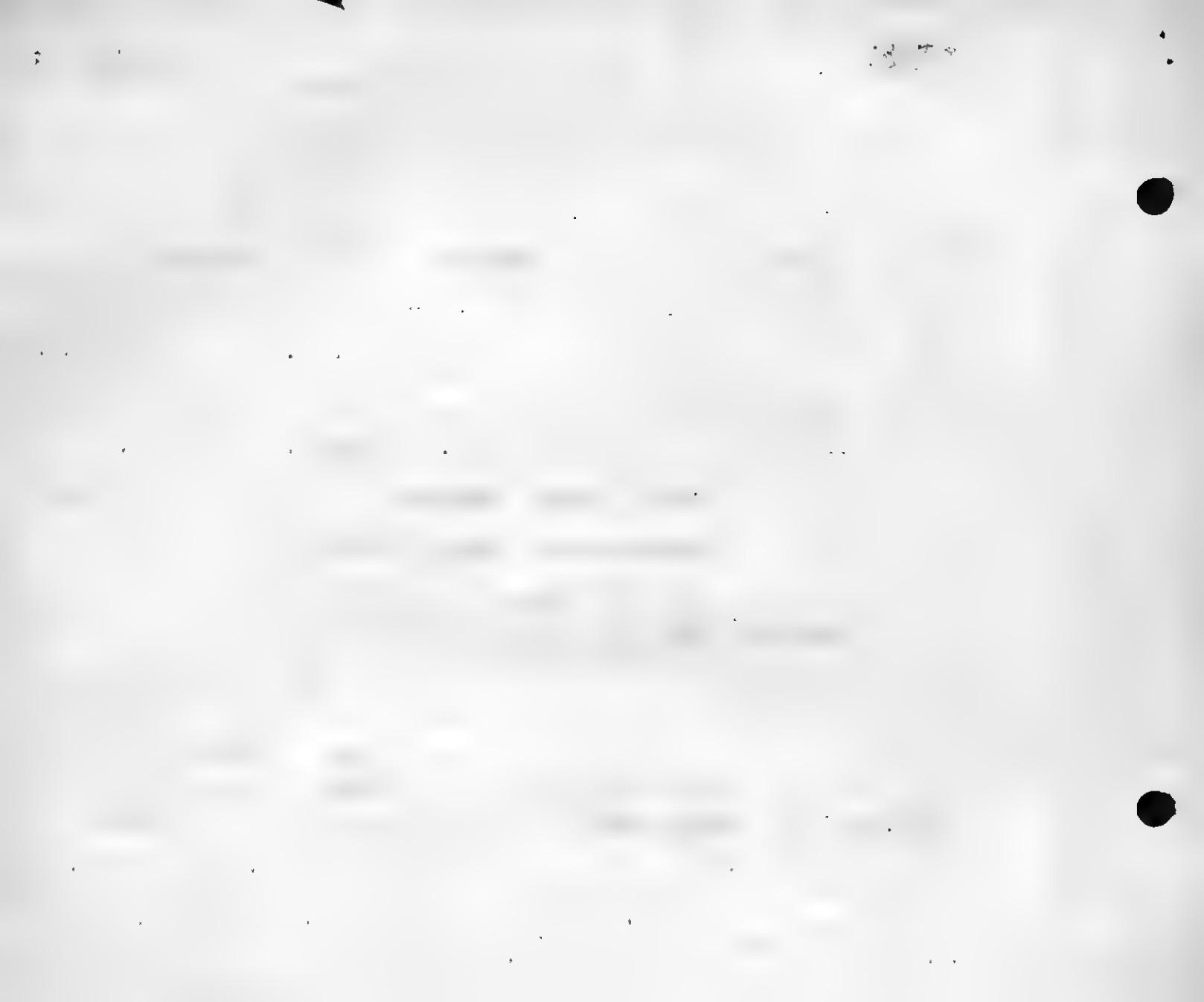
CERTIFICATE OF DEATH

17147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. STATE	
Frederick MARYLAND		Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Frederick		several hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
Frederick Memorial Hospital		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
INDIA		May	LAMBERT
4. DATE OF DEATH		Month	Day Year
		DECEMBER	7 1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>
		Oct. 17-1895	71 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Homemaker		-----	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Frederick Co. Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Edward Jacob Heffner		Annie May Oden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		None	
17. INFDRMANT		Address	
James L. Lambert- Pt. of Rocks, Md. 21777			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>		3-4 hrs.	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420/1</u>			
DUE TO (b) <u>Atherosclerotic Heart Disease</u>		4 yrs.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?	
<u>DIABETES MELLITUS</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <u>Richard C. Reynolds</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 13/9/66	
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds		22d. ADDRESS 804 Toll House Ave.-Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-14-1966	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery
24. FUNERAL DIRECTOR Elwood T. M.R.Etchison & Son		ADDRESS Frederick, Md. 21701	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE DEC 13 1956 jCharles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17158

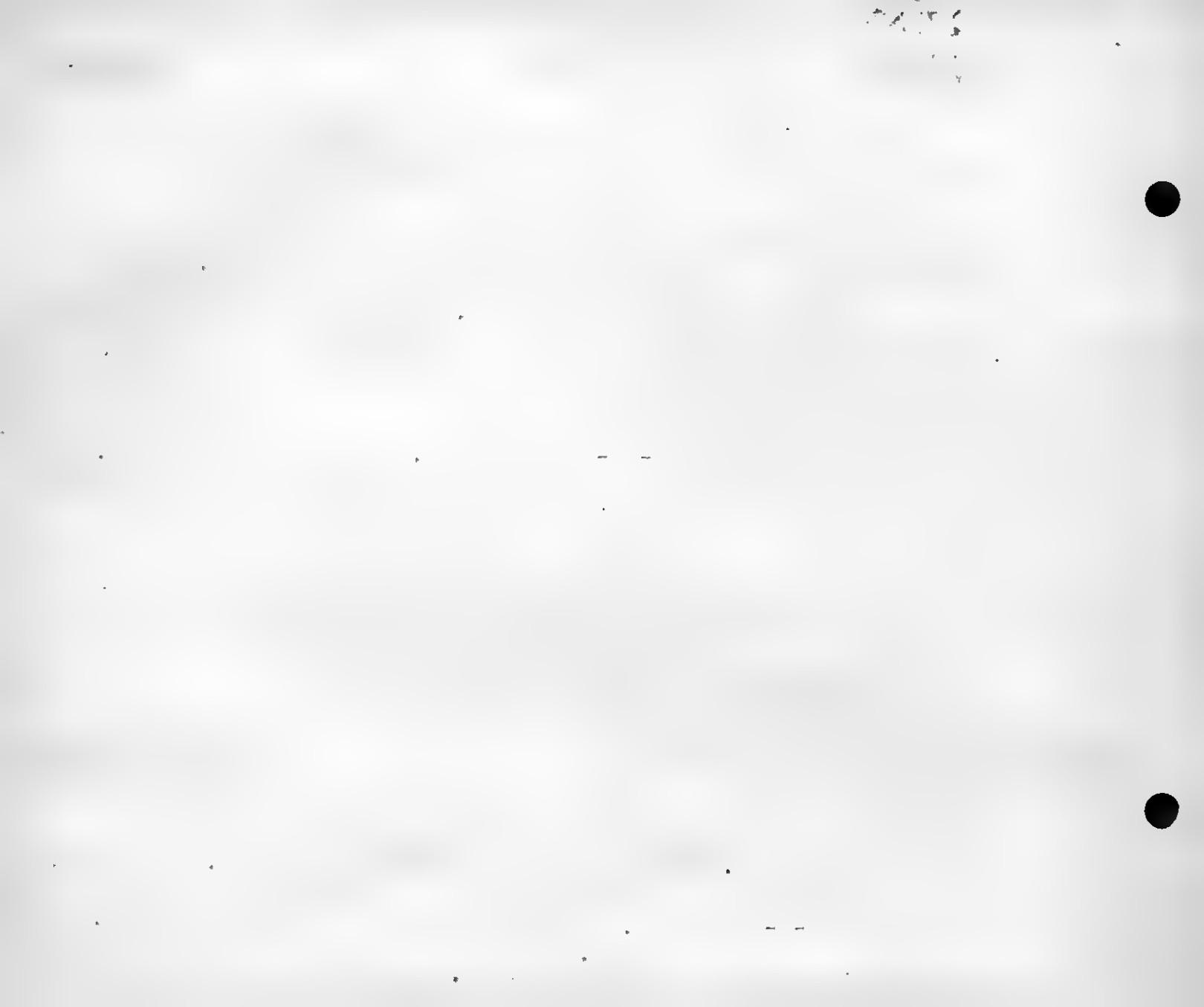
CERTIFICATE OF DEATH

17149

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Detour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edgar	Middle Harrison	Last Long
4. DATE OF DEATH Month Dec.	Day 30	Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 26, 1888	9. AGE (In years at birthday) 78 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph Operator	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Charles Henry Grant Long		14. MOTHER'S MAIDEN NAME Amy Fox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 705-10-8747	17. INFORMANT Earl H. Long 1224 Winston Rd.	Address Baltimore, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO 570.1		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Gastric dilatation stated the underlying cause lost.		DUE TO 6 hrs	
DUE TO Paralytic ileus		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 812 Toll House Ave. Frederick, Md
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Robert J. Thomas		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Robert J. Thomas		22d. ADDRESS 812 Toll House Ave. Frederick, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-2-67	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Tabor Cemetery
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR DATE JAN 3 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

THE INFLUENCE OF THE ENVIRONMENT ON THE GROWTH AND DEVELOPMENT OF THE COTTON PLANT

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			
Frederick		Maryland		a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		Maryland Frederick			
Frederick		Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
Frederick Memorial Hospital				100 E. Church Street			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		
Philemon		Smith		Lansdale	December 31, 1966		
5. SEX		6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)		
Male		White	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	Dec. 31, 1876	90 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			
Retired		Optician		Damascus, Maryland			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?			
Benjamin Franklin Lansdale		Emma Smith		U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
No		214 46 5453		Mrs. Ruth Lansdale, (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		Address					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Congestive Heart Failure				
		DUE TO (c)	Bronchopneumonia				
			Bronchiogenic Carcinoma				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ A.M. from the causes and on the date stated above						22b. DATE SIGNED	
22a. SIGNATURE		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				Dec. 31, 1966	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
Rex R. Martin, M. D.		220 N. Market St. Frederick, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)	
Burial		Jan. 3, 1967		Mount Olivet Cemetery		Frederick, Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Donald M. Fadelley						Charles Judge	
M. R. Etchison & Son, Frederick, Maryland				DATE JAN 1 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15652

CERTIFICATE OF DEATH

17150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b 19 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
3. NAME OF DECEASED (Type or print) ROY WILLIAM LOOKINGBILL		First WILLIAM	Middle ROY
4. DATE OF DEATH November 1 1966	Month November	Day 1	Year 1966
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 4-24-1909
9. AGE (in years last birthday) 57 yrs	10a. USIA. OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Harry W. Lookingbill		
14. MOTHER'S MAIDEN NAME Charlotte Palmer	15. SOCIAL SECURITY NO. 219-01-2276		
16. INFORMANT Mable V. Lookingbill	Address Thurmont, Md.		
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY 420.1			
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) Coronary Atherosclerosis			
DUE TO			
(c)			
INTERVAL BETWEEN ONSET AND DEATH 15 min			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-1-66 , to 12-1-66 , that (I) (we) last saw the deceased alive on 12-1-66 , and that death occurred at HIP M , from causes and on the date stated above.			
22a. SIGNATURE <i>Thomas A. Love</i>		22b. DATE SIGNED 12-2-66	
22c. PHYSICIAN'S NAME (Type) Thomas A. Love		22d. ADDRESS Thurmont, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-4-66	23c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cemetery
23d. LOCATION (City or Town) (County) (State) Thurmont Fred. Co. Md.			
24. FUNERAL DIRECTOR Raymond E. Creager		25a. ADDRESS Thurmont, Md.	25b. REC'D BY REGISTRAR DATE 05 1966
25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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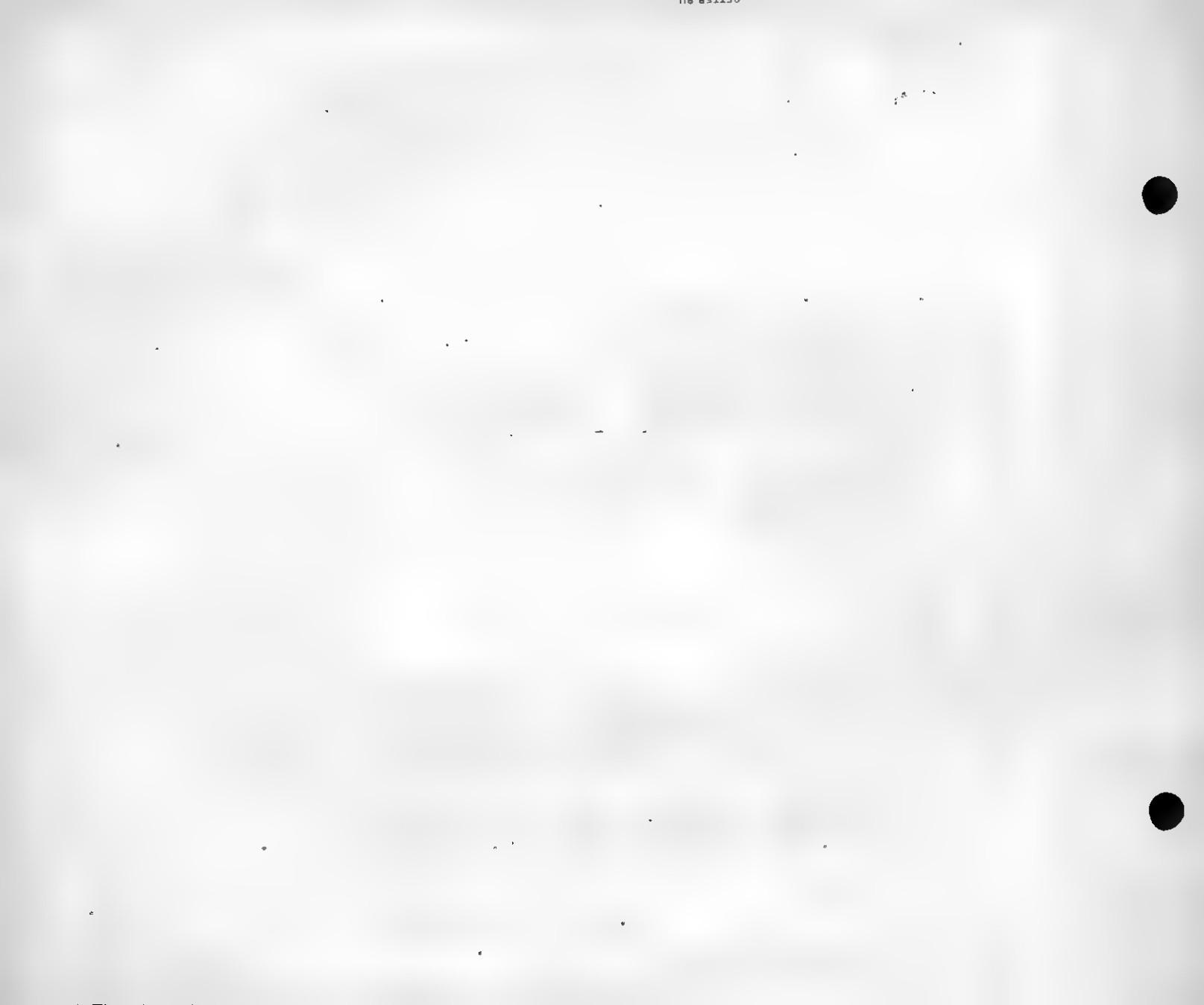
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17159

CERTIFICATE OF DEATH

17151

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle EDWARD	Last MADDEN
4. DATE OF DEATH	Month I2	Day 9	Year 166
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/1884
9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months yrs.	11. IF UNDER 24 HRS. Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired employee		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	
13. FATHER'S NAME Michael Madden		11. BIRTHPLACE (County & State, or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 705-05-7946		17. INFORMANT Lucy M. Madden Brunswick Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebrovascular Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 12/8, 19 to 12/9, 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.		22b. DATE SIGNED 12/9/66	
22a. SIGNATURE A. Austin Pearre, Jr. M.D.		M.O. ATTENDING PHYS. <input type="checkbox"/> M.E. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) A. Austin Pearre, Jr. M.D.		22d. ADDRESS Frederick Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/12/66	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Petersville Md.	
24a. FUNERAL DIRECTOR Late Funeral Home		25a. REC'D BY REGISTRAR Brunswick Md.	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

17160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17152

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City de ay is necessary, please execute the certificate, writing the word "pulling" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Knoxville)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Knoxville) 10.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY MARGARET MAHONEY		4. DATE OF DEATH Month I2 Day 27 Year 66	
S SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/26/09 9. AGE (In years 57 Months 0 days 0 hours 0 minutes Last birthday) yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel B. Eagle		14. MOTHER'S MAIDEN NAME Nellie Virts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 27-12-1289	17. INFORMANT Robert V. Mahoney
		Address Knoxville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X Congestive heart failure (Natural Causes) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) DUE TO Cerebral hemorrhage (c) DUE TO Hypertensive heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED At work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 12/28/66	
ACTUAL SIG. NATURE B.O. Thomas M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23b. DATE THEREOF 12/30/66		Address (Street, city, town, or county) Middletown Fred. Md.	
23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery		23d. LOCATION (City or Town) (County) (State)	
ADDRESS Brunswick Md.		25b. RECEIVED BY REGISTRAR JAN 3 1967	
25a. FUNERAL DIRECTOR Feete Funeral Home		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17161

CERTIFICATE OF DEATH

17153

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Frederick		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN b. 5½ yrs.					
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sabillasville		d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wynelle Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) MARY E. MANAHAN		First MARY	Middle E.				
Last MANAHAN	4. DATE OF DEATH Dec. 15 1966	Month Dec.	Day 15				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Jan. 30, 1876				
9. AGE (In years last birthday) 90 yrs	10. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John Royer	14. MOTHER'S MAIDEN NAME Amanda Warburton	Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No	16. SOCIAL SECURITY NO. 204-30-5205	17. INFORMANT Francis M. Manahan	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO 33IX Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO Arteriosclerotic vascular disease (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cascade	(County) Fred. Co.	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 66 , to Dec 15 , 19 66 , that (I) (we) lost saw the deceased alive on Dec 15 , 19 66 , and that death occurred at 3 P.M. from causes and on the date stated above							
22a. SIGNATURE LeRoy Davis		M.D. LeRoy Davis	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/16/66	
22c. PHYSICIAN'S NAME (Type) LeRoy Davis		22d. ADDRESS Professional Bldg. N. Market St. Fredk. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-18-66	23c. NAME OF CEMEITERY OR CREMATORIAL Bethel Ch.-God Cem.		23d. LOCATION (City or Town) Cascade	(County) Fred. Co.	(State) Md.
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md	25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

Perera Davis

Professional Big N Market of Newark, NJ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												17154					
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)													
Frederick MARYLAND				a. STATE Maryland													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b years													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 326 Park Avenue								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First D. Michael				Last				4. DATE OF DEATH December 31 1966									
(Type or print) Etta								8. DATE OF BIRTH Sept. 9 1880				9. AGE (In years) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.				
5. SEX Female white				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Amos Lease				14. MOTHER'S MAIDEN NAME Mary Houck												Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No				16. SOCIAL SECURITY NO. 216-46-6278				17. INFORMANT Russell L. Michael				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH 1 st d	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Congestive Heart Failure								DUE TO (b) Intestinal Obstruction					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO (c) Adhesions & Obstruction					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 7/1, 1965, to 12/31, 1966, that (I) (we) last saw the deceased alive on 12/31, 1966, and that death occurred at 12:30 AM, from the causes and on the date stated above.												22b. DATE SIGNED 12-31-66					
22a. SIGNATURE James B. Thomas								ATTENDING PHYS. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS Prof. Bldg. - Frederick Md. 21701					
22c. PHYSICIAN'S NAME (Type) Dr. James B. Thomas																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 4-1967				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Olivet Cemetery				23d. LOCATION (City, town or county) (State) Frederick, Md. 21701					
24. FUNERAL DIRECTOR Wood J. Whitmore												25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
M.R. Etchison & Son								Frederick-Md. 21701				DATE JAN 3 1967 Charles Judge					



IN HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

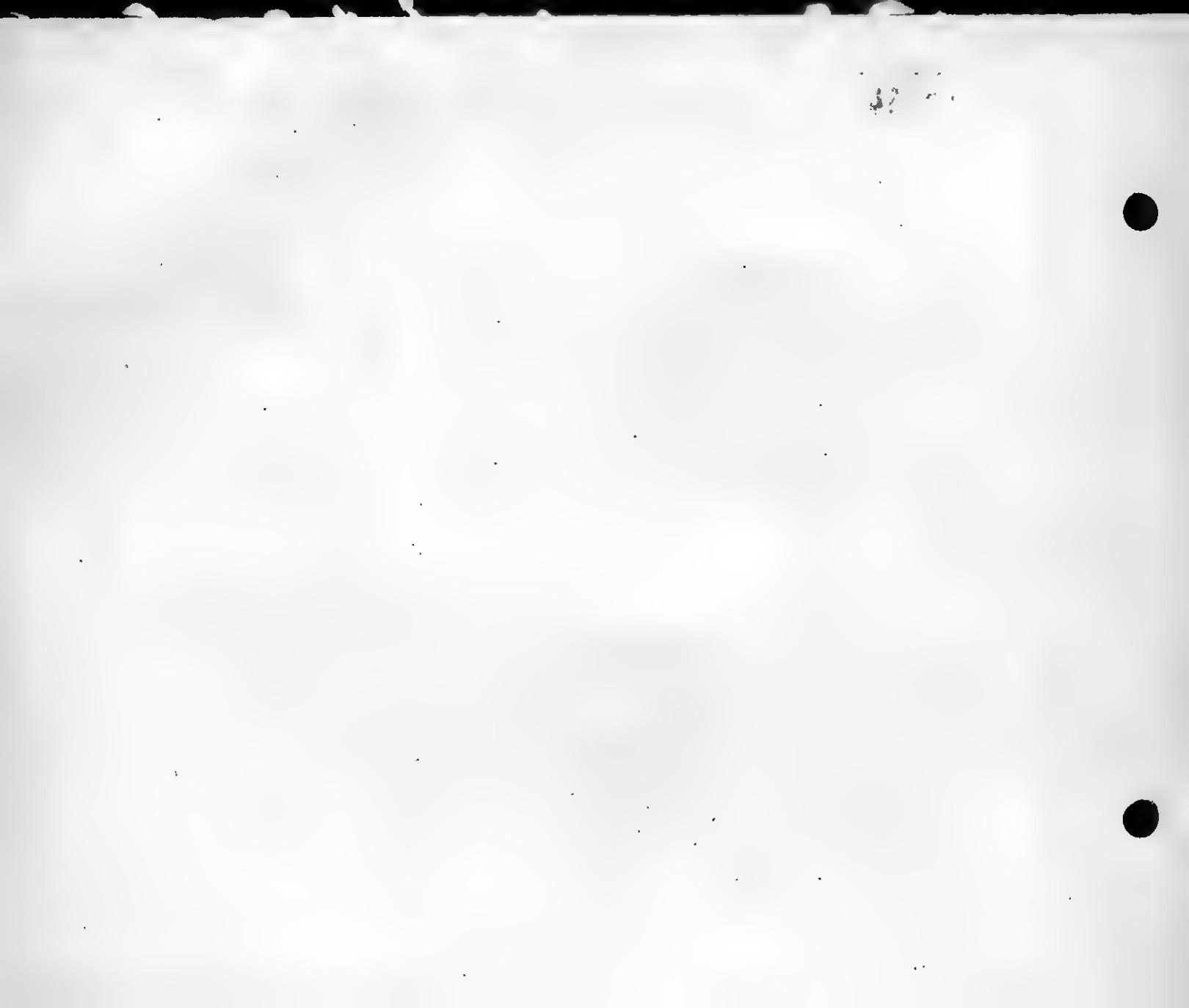
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17163

CERTIFICATE OF DEATH

1715

1. PLACE OF DEATH a. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE Maryland		b. COUNTY Frederick											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		c. LENGTH OF STAY IN 1b		2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Middletown											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Montague Co. Home for Aged		e. STREET ADDRESS				f. IS RESIDENCE ON A FARM?													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>											
Female		Amanda	E.	Miller	December	8,		1966													
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. FUNDER 1 YEAR	11. FUNDER 24 HRS	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME											
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 13, 1884	81 yrs.	Months	Days	Hours	John Edward Miller	Sarah Pressler											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
Housekeeper		Private Homes		Frederick Co. Maryland		U.S.A.		No		(If yes give rank or date of service)				Maryland.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Intestinal obstruction		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED?		19. WAS AUTOPSY PERFORMED?		19. WAS AUTOPSY PERFORMED?		19. WAS AUTOPSY PERFORMED?							
153.3		DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) DUE TO	Carcinoma of the sigmoid		36 hours.		YES <input type="checkbox"/>		NO <input type="checkbox"/>		7 years.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year		Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
19																					
21. I certify that (I) (this hospital) attended the deceased from Oct 25, 1966, to Dec 8, 1966, that (II) (we) last saw the deceased alive on Dec 8, 1966, and that death occurred at 7 PM, from the causes and on the date stated above.														22a. SIGNATURE		LeRoy T. Davis		22b. DATE SIGNED		12/9/66	
22c. PHYSICIAN'S NAME (Type)		Dr. LeRoy T. Davis		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county)															
Burial		12/11/66		Reformed Cemetery		Middletown, Fred. Co. Md.															
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Gladhill Company, Middletown, Maryland														DATE DEC 12 1966		Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

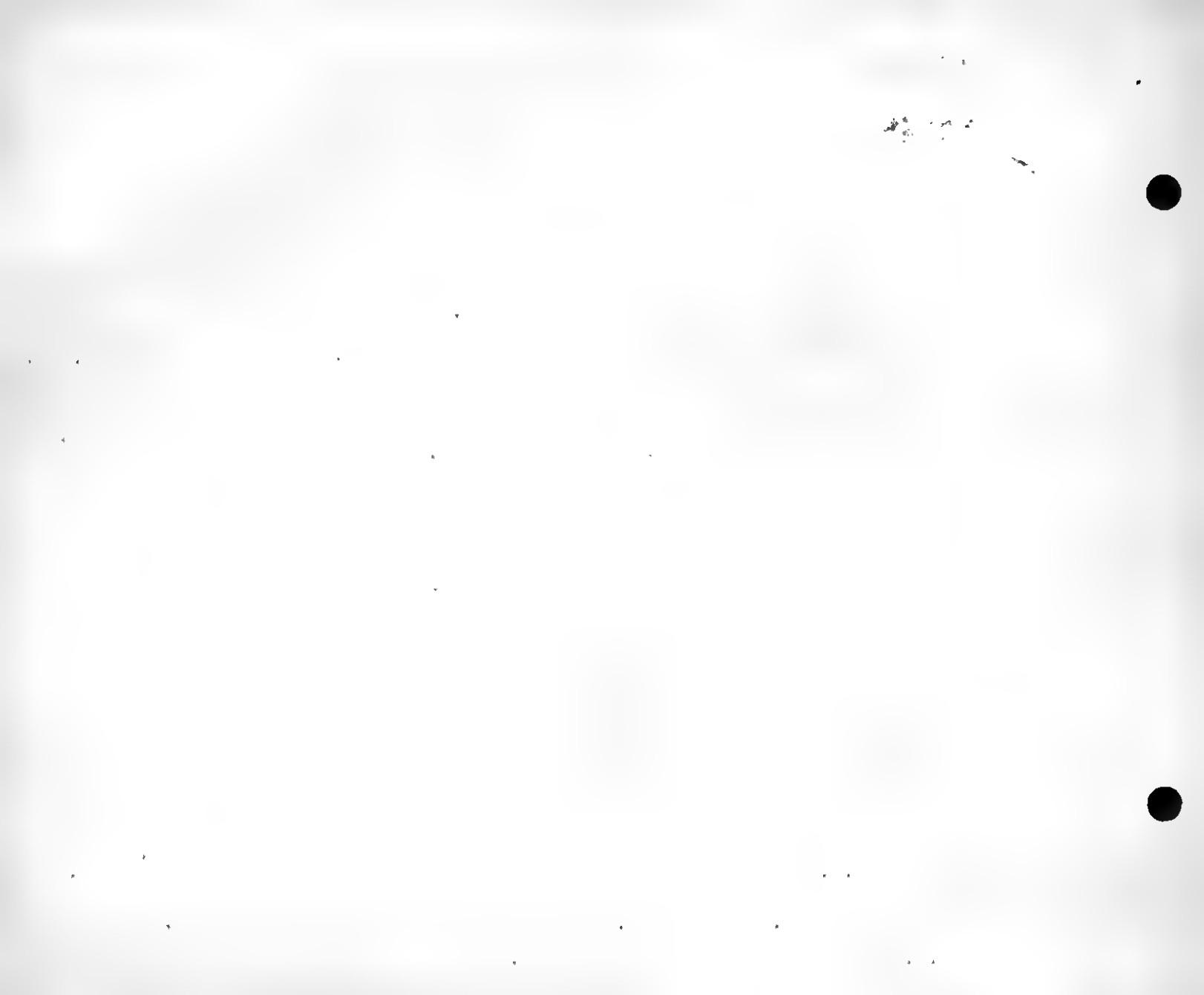
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

17164

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17156

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 535 Wilson Place		e. STREET ADDRESS 535 Wilson Place	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Iva Lee Moon		First Iva	Middle Lee
Last Moon		4. DATE OF DEATH December 26-1966	Month Year Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18-1905
9. AGE (in years at birthday) 61 yrs		F. UNDER 1 YEAR Months 0	I. UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Dominick Avella		14. MOTHER'S MAIDEN NAME Sadie Purnell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219-20-3018	17. INFORMANT Truman W. Moon-535 Wilson Place-Frederick-
18. INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>330A</i>		Congestive Heart Failure	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost</i>			
(b)		Aspiration Asphyxia- Gastric Contents	
DUE TO <i>lost</i>		Ruptured Aneurism- Circle of Willis	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O.Thomas</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O.Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED Dec. 26-1966			
Address (Street, city, town, or county) Frederick, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 29-1966	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State)			
23e. RECD BY REGISTRAR DATE DEC 29 1966		23b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR M.R.Etchison & Son		ADDRESS Frederick, Md. 21701	



M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17165

CERTIFICATE OF DEATH

17152

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR KENAI</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> RURAL, 1	
c. LENGTH OF STAY IN lb <u>YEARS</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MOLLIE SNADER NICODEMUS</u>		First <u>M</u>	Middle <u>SNADE</u>
Last <u>NICODEMUS</u>		Last <u>DEC</u>	Month <u>12</u>
4. DATE OF DEATH	Day <u>19</u>	Year <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 4-1880</u>
9. AGE (In years last birthday) <u>86 yrs</u>		10. KIND OF BUSINESS OR INDUSTRY <u>CHEESEKEEPER OWN HOME</u>	11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN T SNADER</u>	
14. MOTHER'S MAIDEN NAME <u>SARAH CLENS. NY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>220-34-0008</u>		17. INFORMANT <u>ELI NICODEMUS NEW WINDSOR MD</u>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>arteriosclerotic CVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
(b) <u></u>			
(c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/11/64</u> , 19 to <u>12/12/64</u> , 19, that (I) <u>have</u> lost saw the deceased alive on <u>12/14/64</u> , 19, and that death occurred at <u>730PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Robertson</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12/12/64</u>
22c. PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>		22d. ADDRESS <u>New Windsor, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>12/15/66</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>LINGANORE</u>
23d. LOCATION (City or Town) (County) (State) <u>UNIONVILLE MD</u>		23e. REG'D BY REGISTRAR <u>Judge</u>	
24. FUNERAL DIRECTOR <u>A. Hartzell & Son New Windsor</u>		ADDRESS	DATE <u>DEC 16 1966</u>
25a. REC'D BY REGISTRAR <u>Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

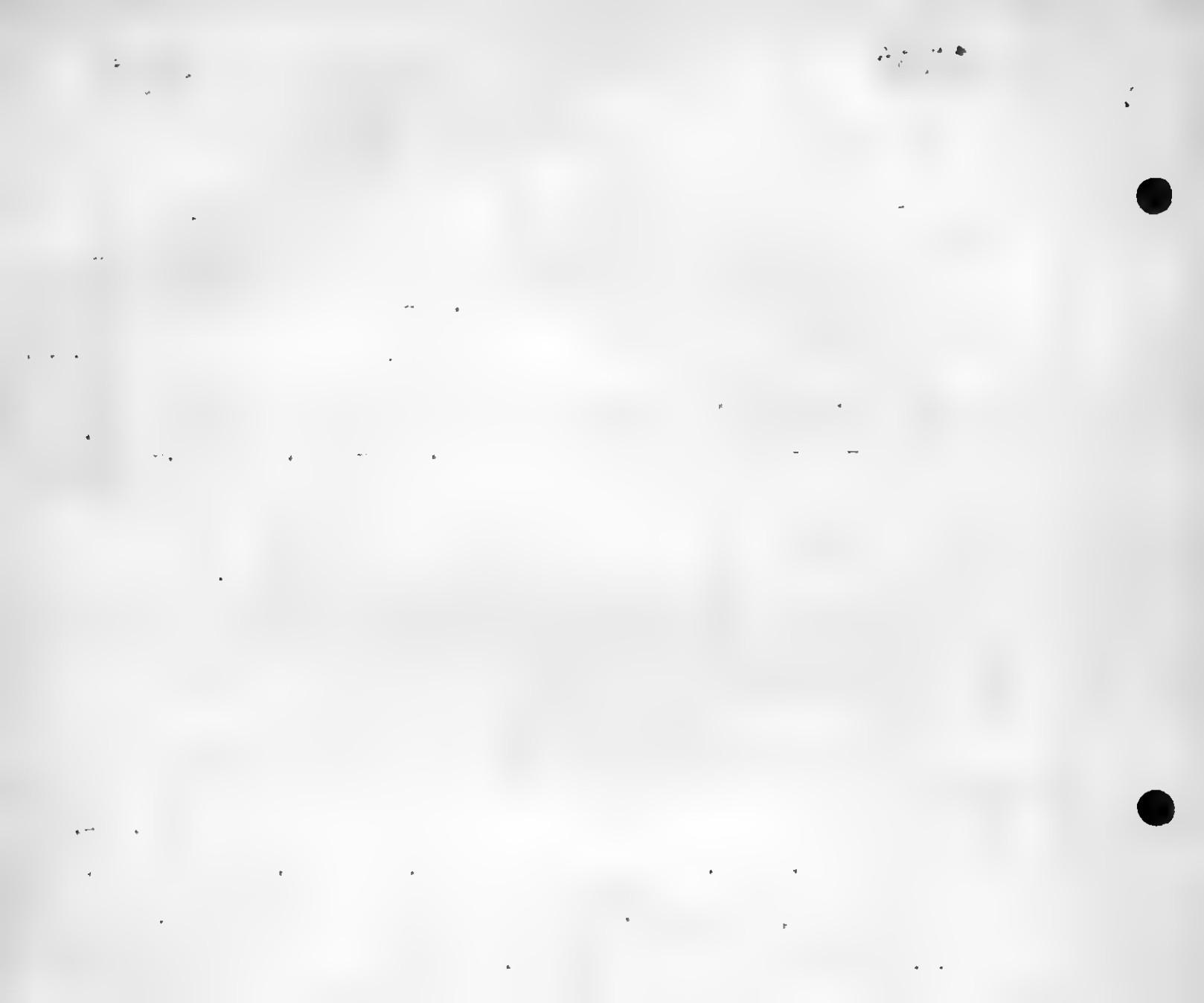
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17166

CERTIFICATE OF DEATH

17158

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick years c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA - Frederick Memorial Hospital		d. STREET ADDRESS 459 West South St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sherman Summerfield Orem		First	Middle
4. DATE OF DEATH December 24- 1966		Last	Month Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Nov. 11-1895		9. AGE (in years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Work		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nimrod S. Orem, Sr.	
14. MOTHER'S MAIDEN NAME Florence Marsh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Nimrod S. Orem-459 W. South St.- Frederick, Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. Ix		DUE TO Hypertensive arteriosclerotic cerebral & cardiovascular disease	
DUE TO Cerebral hemorrhage & thrombosis		10 years 6-8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 , to 12-24-1966 , that (I) (we) last saw the deceased alive on 12-23- 1966 , and that death occurred at 7A M, from the causes and on the date stated above.		22b. DATE SIGNED Dec. 24-1966	
22a. SIGNATURE Rex R. Martin		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 220 N. Market St.- Frederick, Md. 21701	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 27-1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Olivet Cemetery Whitmore
24. FUNERAL DIRECTOR M.R.Etchison & Son		25a. REC'D BY REGISTRAR DEC 28 1966	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	



Item 20 Film 384 1-3-67 a MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE
HEALTH DEPT.

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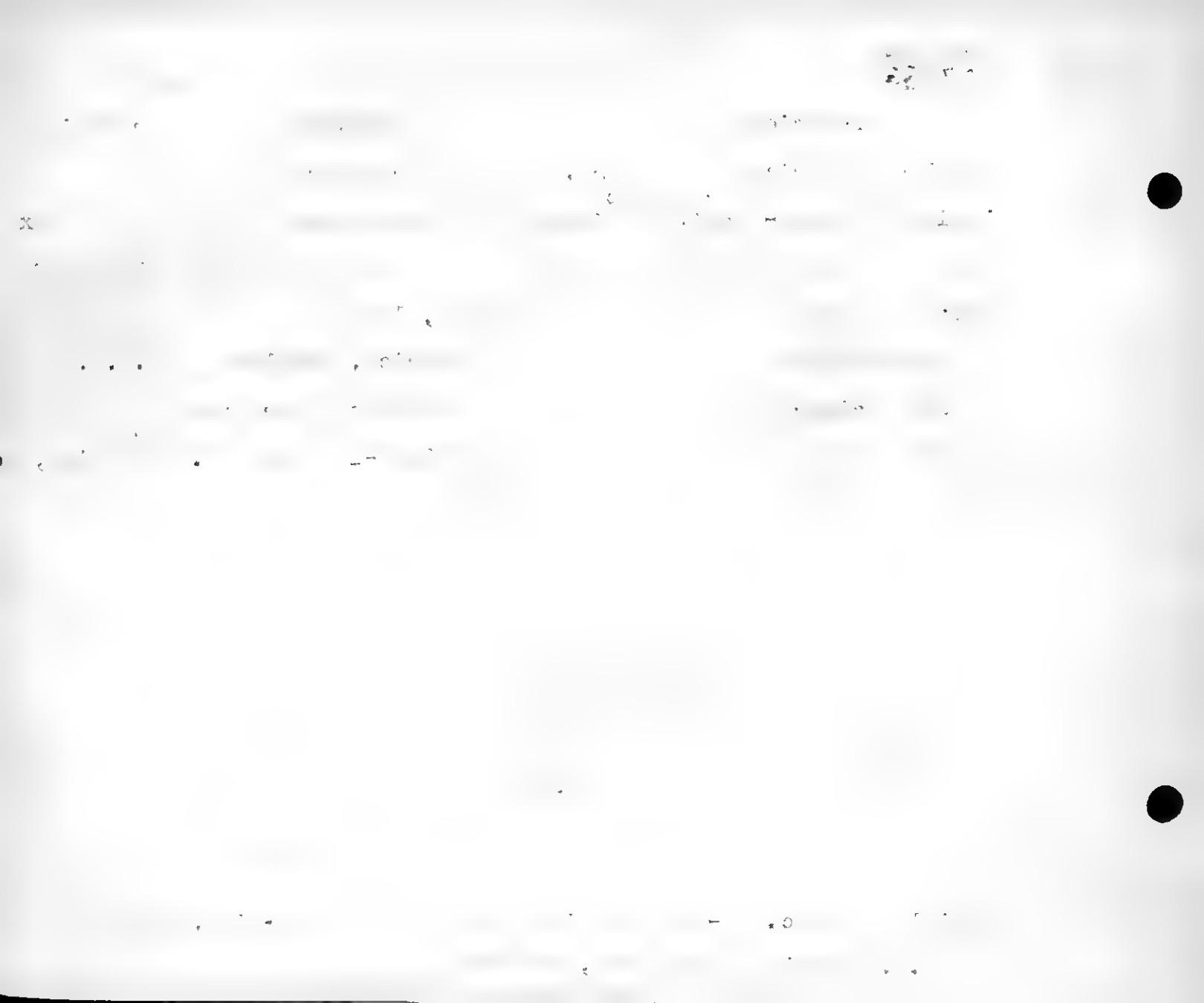
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17167

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17159

1 PLACE OF DEATH a. COUNTY Frederick		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frederick		c. LENGTH OF STAY IN lb hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in residence)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
Reels Mill Road - Louis Battistone		d. STREET ADDRESS 116 East Street	
3 NAME OF DECEASED (Type or print) BARRY LYNN PALMER	First BARRY	Middle LYNN	Last PALMER
4 DATE OF DEATH December 23 1966	Month December	Day 23	Year 1966
5. SEX Male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED NEVER MARRIED	8 DATE OF BIRTH May 9, 1961
9 AGE (in years last birthday) 5 yrs	F UNDER 1 YEAR Months 5	I F UNDER 24 HRS Days 0	Hours 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****	10b KIND OF BUSINESS OR INDUSTRY *****	11 BIRTHPLACE (State or foreign country) Frederick, Maryland	12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME John Palmer	14 MOTHER'S MAIDEN NAME Margaret Morrison		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No	16. SOCIAL SECURITY NO None	17 INFORMANT John Palmer-116 East St. Frederick, Md.	Address Maryland
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 19610 19610 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { b DUE TO c DUE TO d e f g h i j k l m n o p q r s t u v w x y z		INTERVAL BETWEEN ONSET AND DEATH	
DROWNING			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> (Cause of Death)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Slidin' down hill, when on a snow - sled broke on the ice and he was caught under the ice.	
20c TIME OF INJURY Month, Day, Year Hour a.m. 11:20 p.m. Dec 23 1966		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) pond		20f. (City or town) Mr. Frederick	
		(County) (State) Fred. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) 12/23/66			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Dec. 25-66	
23c NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		23d LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR C.E. Hicks 111 Frederick, Maryland		ADDRESS	
		25a REC'D BY REG STRAR DATE DEC 27 1966	
		25b REGISTRAR'S SIGNATURE James J.age	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

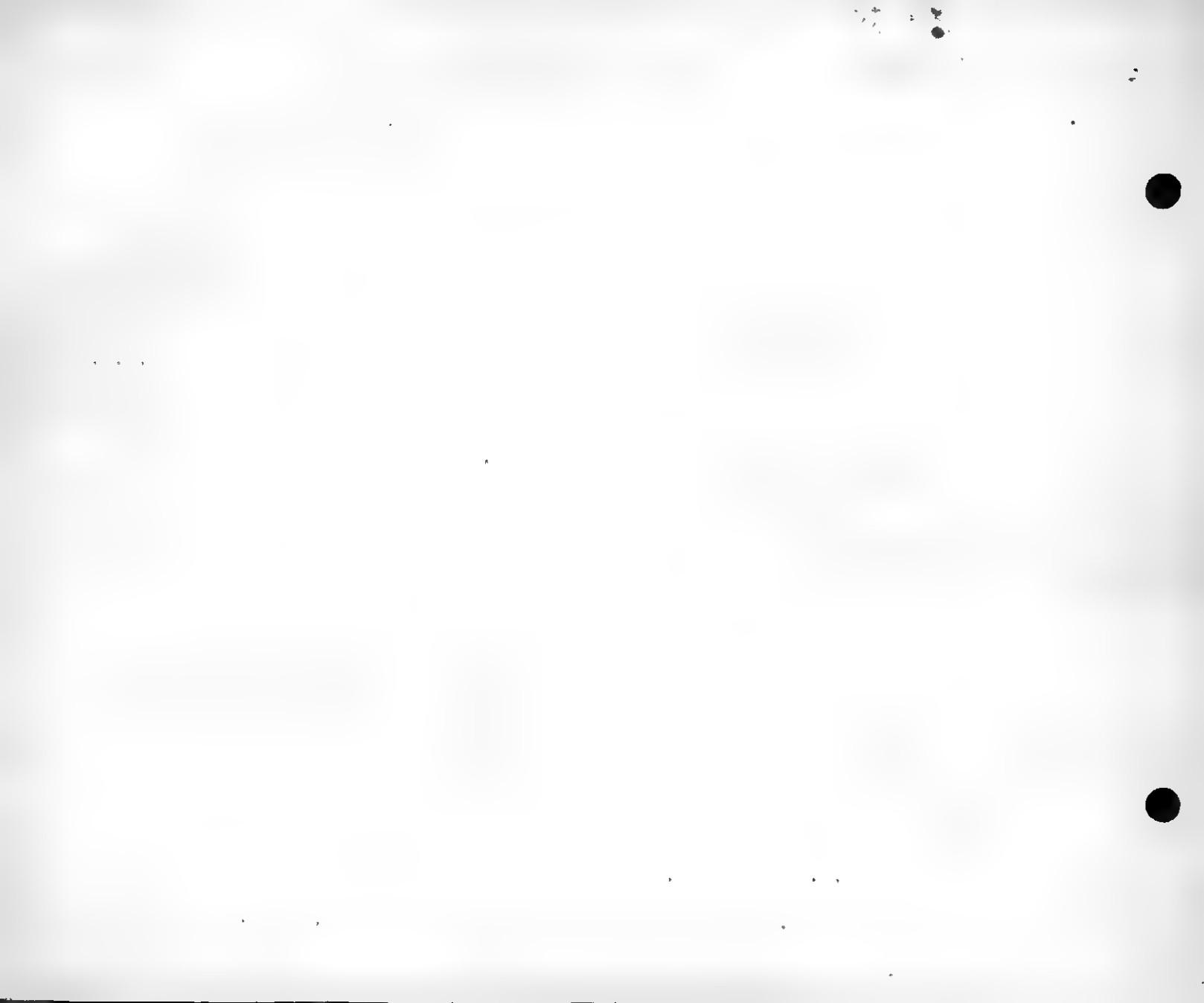
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17168

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17160

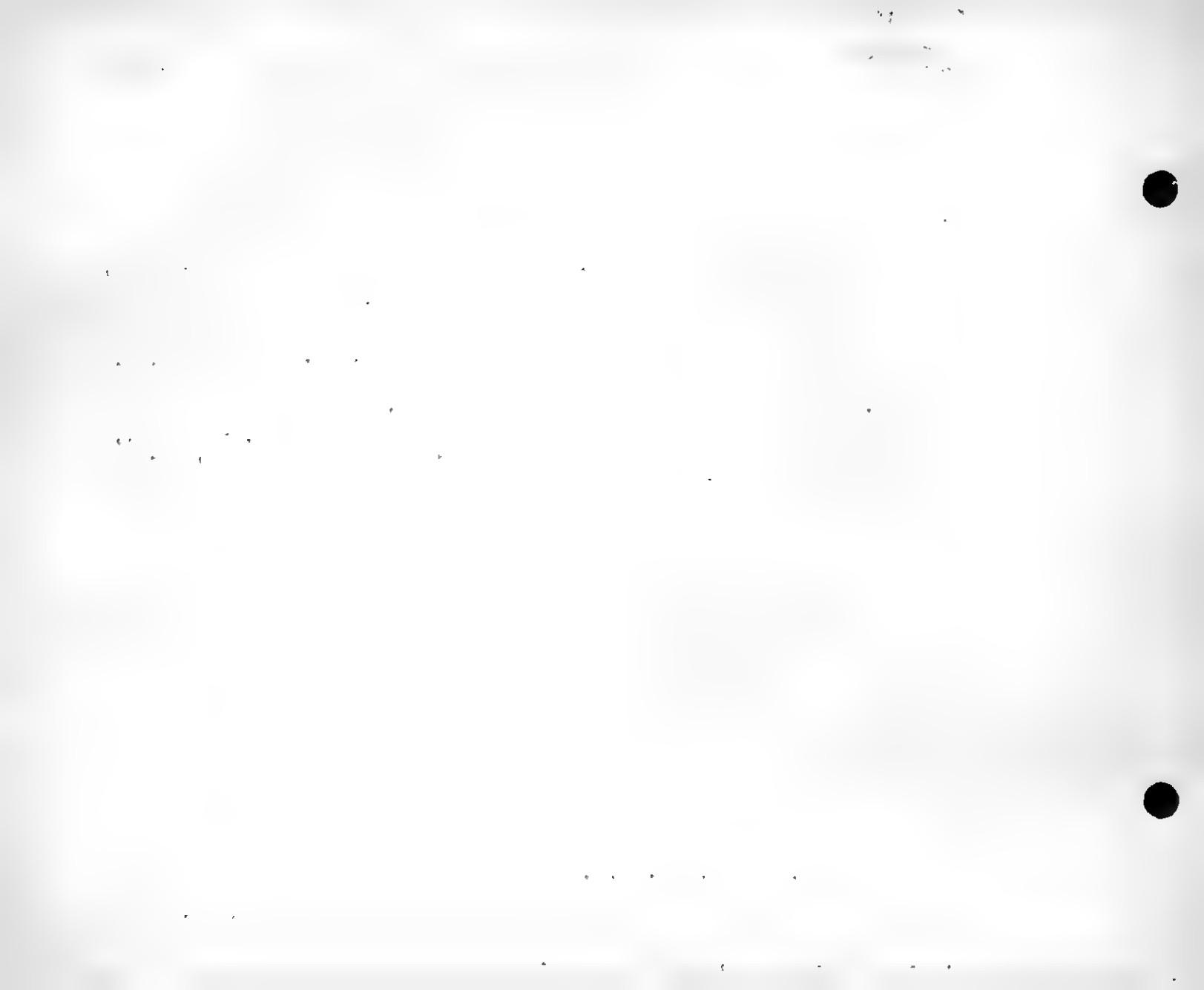
1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 219 West Fifth Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rear 602 Trail Avenue						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Douglas Clifford Paust		First	Middle	Lost	4. DATE OF DEATH Month December 15-	Day	Year 19 66
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1949	9. AGE (In years at last birthday) 17 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Pauline Baker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO. 214 48 2852		17. INFORMANT Mrs. Pauline Kline (Same as item # 2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 891.6		DUE TO (b)		Carbon monoxide poisoning		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Carbon monoxide poisoning, with car running in close garage				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. Dec. 15 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage		20f. (City or town) (County) (State) Frederick, Frederick Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B.O. Thomas		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-15-1966	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 17, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Resthaven Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Nr. Hansonville, Md	
24. FUNERAL DIRECTOR Donald J. Etchison		ADDRESS Fadeley M. R. Etchison & Son, Frederick, Maryland		25a. REG'D BY REGISTRAR DATE DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles J. George	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 FOR STATE HEALTH DEPT. 17169 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17161									
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick				
c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 128 West Patrick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 128 West Patrick Street									
3. NAME OF DECEASED (Type or print) ERNEST		First L. Middle PERKINS		Last		4. DATE OF DEATH December 7, 1966			
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED Separated <input type="checkbox"/>		8. DATE OF BIRTH 21 April 1926		9. AGE (In years at birthday) 40 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day Laborer		11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Harry T. Perkins				14. MOTHER'S MAIDEN NAME Mary E. Himes					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 212 14 6470		17. INFORMANT Harry T. Perkins		404 N. Bentz St. <small>Address</small> Frederick, Md. 21701			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive fatty infiltration of liver DUE TO Chronic alcoholism and idiopathic epilepsy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Early cirrhosis of liver DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. TIME OF INJRY Month, Day, Year Hour a.m. p.m. 19 20d. INJRY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJRY (Home, farm, factory, street, office building, etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE B.O.Thomas EXAMINER'S NAME (Type) B.O.Thomas, Sr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 12-7-66					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12/10/66		23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION (City or town) (County) (State) Frederick, Md. 21701					
24. FUNERAL DIRECTOR Frank R. Smith ADDRESS M. R. Etchison & Son, Frederick, Md. 21701				25a. REC'D BY REGISTRAR DATE DEC 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

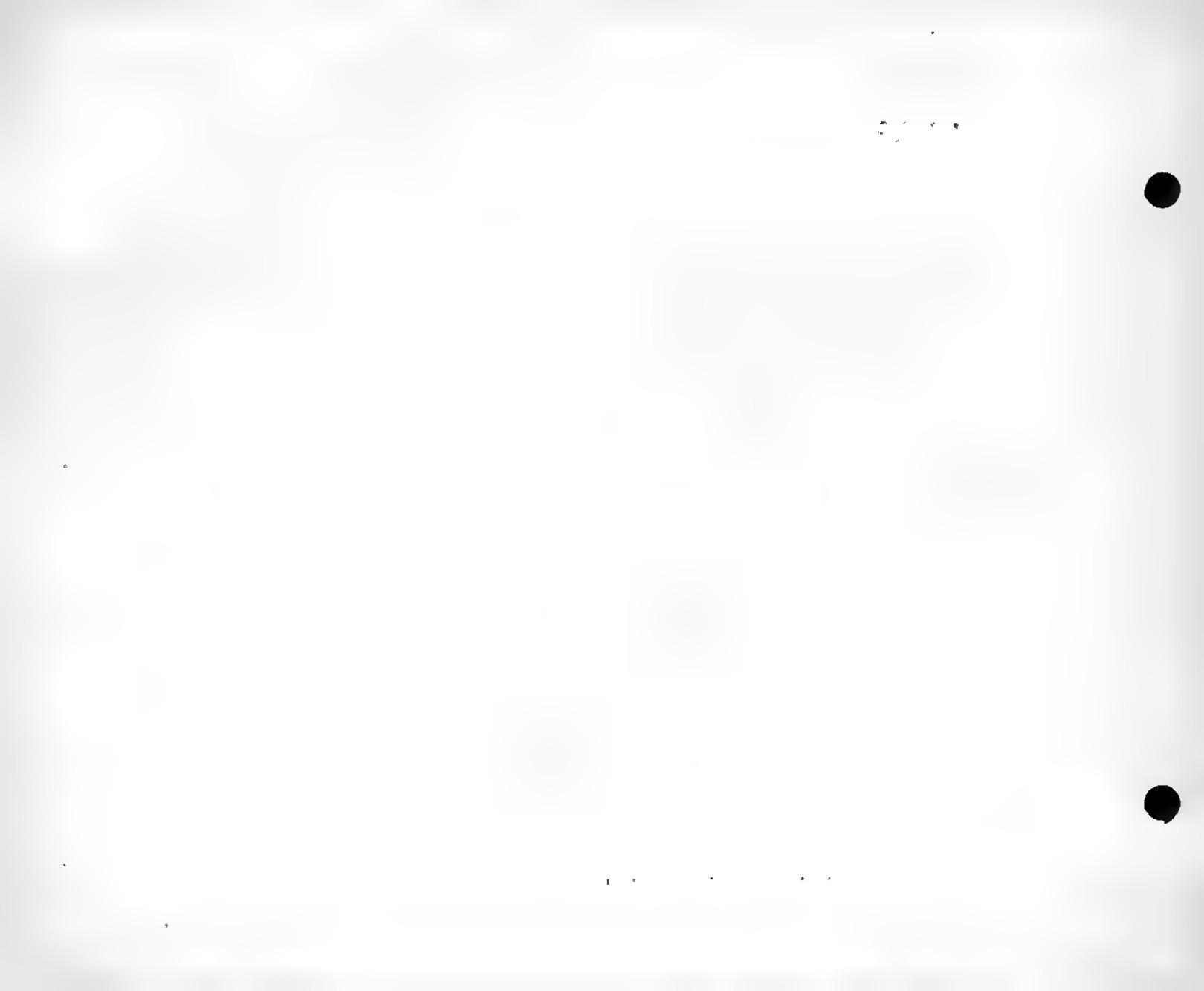
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17170

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17162

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Airy		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Airy			c. LENGTH OF STAY IN 1b 22 Years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 4			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) AGNES ELAINE PERRY			First	Middle	Last
4. DATE OF DEATH December 4, 1966	Month	Day	Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 21, 1903	9. AGE (in years last birthday) 63 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY 		
11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Howard Ensor			14. MOTHER'S MAIDEN NAME Mary McFatridge		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 212-14-0722		
17. INFORMANT Mrs. Ethel Merriman			18. ADDRESS 2228 Keswick Rd. Salisbury, Md.		
19. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure			INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) Acute alcoholism					
(c) Exposure to freezing temperature					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour p.m. pm 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O.Thomas			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) B.O.Thomas, Sr. M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23b. DATE THEREOF 12/8/1966			Address (Street, city, town, or county) Leisters Cemetery		
23c. NAME OF CEMETERY OR CREMATORIAL Leisters Cemetery			23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.		
24. FUNERAL DIRECTOR C. M. Waltz			25a. REC'D BY REGISTRAR DEC 9 1966		
ADDRESS Box 241 St. Kesville, Md.			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detained for us all the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

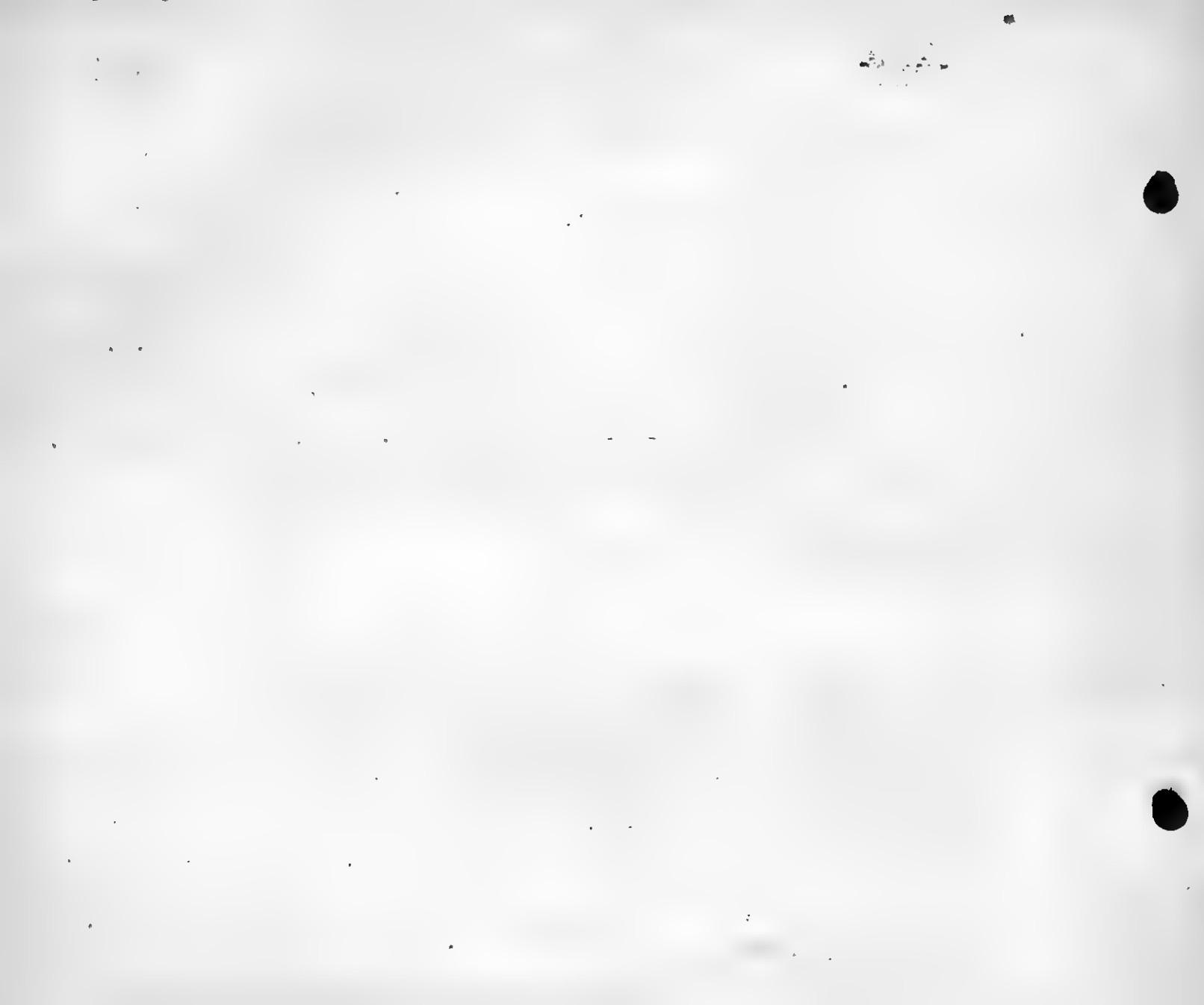
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17171

CERTIFICATE OF DEATH

17163

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Loretta	Middle Elizabeth	Last Phillips
4. DATE OF DEATH Month Dec	Day 11	Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/1904
9. AGE (In years at birthday) 62	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (County & State, or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Silas A. Smith	14. MOTHER'S MAIDEN NAME Elizabeth M. Horan	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no	
16. SOCIAL SECURITY NO. 226-09-9798		17. INFORMANT Carroll D. Phillips	Address Brunswick Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive pulmonary metastases DUE TO (b) Adenocarcinoma of breast INTERVAL BETWEEN ONSET AND DEATH 6 mo. Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 110X DUE TO (c) Diabetes mellitus 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec 4 , 1966, to Dec 11 , 1966, that (II) (we) last saw the deceased alive on Dec 11 , 1966, and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Henry V. Chase	22b. DATE SIGNED 11 Dec '66		
22c. PHYSICIAN'S NAME (Type) Henry V. Chase	22d. ADDRESS 804 Toll House Ave, Frederick, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/14/66	23c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery Winchester	23d. LOCATION (City, town or county) Va.
24. FUNERAL DIRECTOR Feele Funeral Home	ADDRESS Brunswick Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
DATE DEC 14 1966			



1 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17172

CERTIFICATE OF DEATH

17164

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		d. STREET ADDRESS E. Main St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res. Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Elmer	Middle J.	Last Pittinger	4. DATE OF DEATH December 30 1966	Month Year	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1881	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Maintance of Ways		10b. KIND OF BUSINESS OR INDUSTRY W.M. Railroad		11. BIRTHPLACE (County & State or foreign country) Weedsbere, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Pittinger		14. MOTHER'S MAIDEN NAME Elizabeth Engle					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-7012		17. INFORMANT Mrs. Ethel Pittinger		Address Thurmont, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY H.A.D.		IMMEDIATE CAUSE (a) Heart disease arterio sclerotic type		INTERVAL BETWEEN ONSET AND DEATH 5 mos.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 		(b) Ateriosclerosis - generalized		(c) 		14yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
None		None				19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 23 , 1966, to Dec. 30 , 1966 that (I) (we) last saw the deceased alive on Dec. 30 1966, and that death occurred of 96 M, from causes and on the date stated above.							
22a. SIGNATURE James K. Gray		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS 12-E Main Thurmont Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Taber		23d. LOCATION (City or Town) (County) (State) Rocky Ridge Md. Fred Co	
24. FUNERAL DIRECTOR Raymond E. Clegg		ADDRESS Thurmont, Md		25a. REC'D BY REGISTRAR Jan 3 1967		25b. REGISTRAR'S SIGNATURE James K. Gray	

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17173

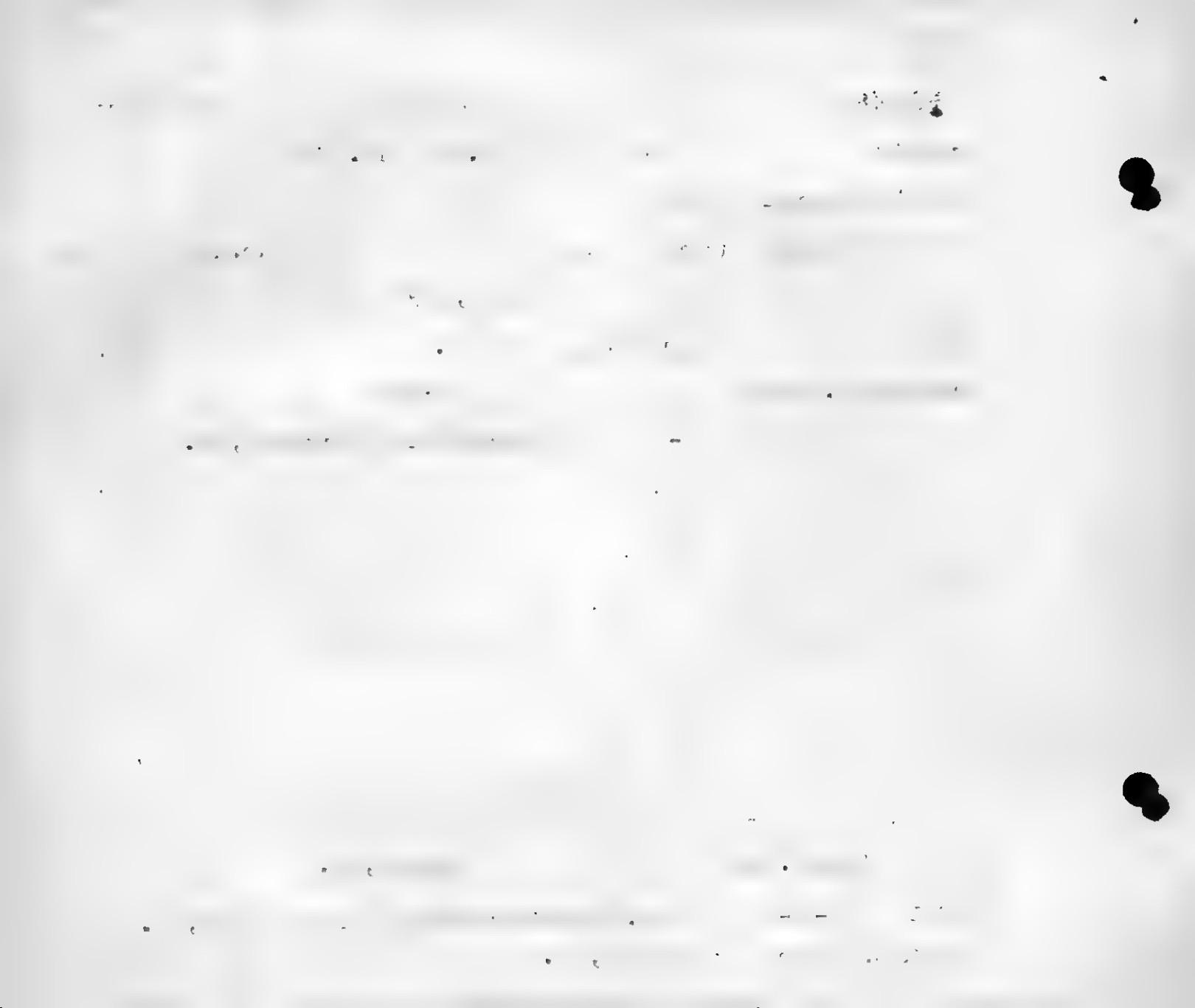
CERTIFICATE OF DEATH

Reg. Dist. No.

17165

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. #3 Mt. Airy		d. STREET ADDRESS 15-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial		DOA		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Granville		First (None)	Middle Poole	Last 	4. DATE OF DEATH Dec. 22	Month 166	Day 	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1891	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Truck Farmer		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Greenberry G. Poole		14. MOTHER'S MAIDEN NAME Ida Brown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. •		INFORMANT Monroe Poole		Address Frederick, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, etc. (b) <i>Coronary thrombosis</i> DUE TO (c) <i>Pulmonary edema</i>								
INTERVAL BETWEEN ONSET AND DEATH 10 years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) DAMASCUS, MD.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 10/21/61 , 1961, to 12/22/66 , 1966, that I last saw the deceased alive on 12/22/66 , 1966, and that death occurred at M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) DAMASCUS, MD.								
ACTUAL SIGNATURE <i>James P. Kerr</i> DATE SIGNED 12/23/66								
PHYSICIAN'S NAME (Type) James P. Kerr		Damascus, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-66		22c. NAME OF CEMETERY OR CREMATORIUM Mont. Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Claggettsville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.						
		24a. REC'D BY REGISTRAR DEC 27 1966						
		24b. REGISTRAR'S SIGNATURE <i>John J. Kerr</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

17174

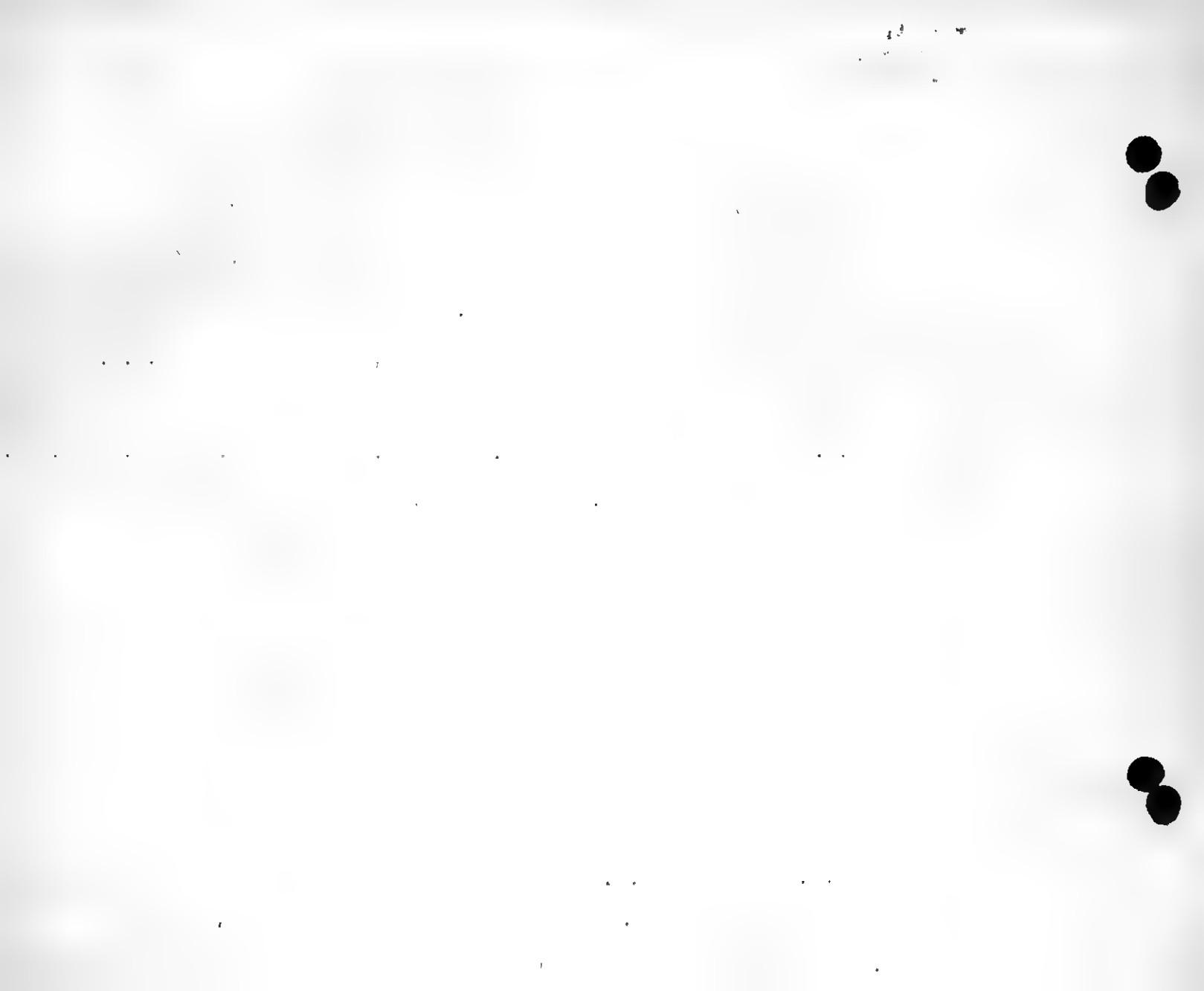
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17166

If dry, If wet, If is necessary, please excute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN MD XXXXX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Frederick Memorial Hospital		e. STREET ADDRESS 319 East 2nd Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle POPLO		4. DATE OF DEATH Month December Day 9, Year 1966	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 15, 1915		9. AGE (In years at birthday) 51 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Mechanic		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Bysville, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Poplowski		14. MOTHER'S MAIDEN NAME Anna Osage	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes N.W. 2		16. SOCIAL SECURITY NO 705-12-5720	
17. INFORMANT Mrs. Evelyn P. Poplo		Address 319 E. 2nd St. Fred. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured Spine; Transected Spinal Cord; Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Due to Curved Atria of Heart; Crushed Chest (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Hit by train	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 12 pm 9-1966		20d. INJURY OCCURRED At work <input type="checkbox"/> Not At work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bus, etc.) Balto. subway		20f. (City or town) Frederick (County) Frederick (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) B.O. Thomas, Sr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-12-1966	
23c. NAME OF CEMETERY OR CREMATORIAL St. Michael Cemetery		23d. LOCATION (City or Town) Frostburg (County) Maryland (State)	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Maryland	
25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE jCharles Judge	
DATE DEC 12 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17175

CERTIFICATE OF DEATH

17167

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARRY	Middle LEE	Last REID	4. DATE OF DEATH Month December Day 13, Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1876	9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Pleasantville, Maryland	
13. FATHER'S NAME Daniel Milton Reid		14. MOTHER'S MAIDEN NAME Susan Sabinia Mitchell		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Wm. B. Pollitt, RFD#1, Harpers Ferry, W.Va.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above.					
22a. SIGNATURE <u>A. Austin Pearre, Jr.</u>		22b. DATE SIGNED 12/13/66			
22c. PHYSICIAN'S NAME (Type) A. Austin Pearre, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/16/66	23c. NAME OF CEMETERY OR CREMATORIUM Samples Manor Cemetery	23d. LOCATION (City, town or county) Samples Manor, Maryland (State)	
24. FUNERAL DIRECTOR <u>Donald Ziebler</u>		ADDRESS Harpers Ferry, W.Va.	25a. REC'D BY REGISTRAR Date DEC 21 1966	25b. REGISTRAR'S SIGNATURE Judge	



1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
Frederick MARYLAND				b. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick									
c. LENGTH OF STAY IN lb													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 624 Wilson Place									
3. NAME OF DECEASED (Type or print)				First Alice	Middle Kline	Last Ridgely	4. DATE OF DEATH	Month December	Day 28	Year 1966			
5. SEX Female				6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27-1902	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Secretary				11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.					
13. FATHER'S NAME Charles Wm. Kline				14. MOTHER'S MAIDEN NAME Mellie Crum				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-24-2103				17. INFORMANT Mrs. Alvin S. Klein-624 Wilson Place- Address Frederick-Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteria</i>				INTERVAL BETWEEN ONSET AND DEATH									
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>21-1X</i>				DUE TO (b) <i>Arterial failure</i>									
				DUE TO (c) <i>Arteriosclerosis - Coronary Disease</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Peripheral Vascular Disease -</i>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)					
21. I certify that (I) (this hospital) attended the deceased from <i>12-28-1966</i> , to <i>12-28-1966</i> , that (I) (we) last saw the deceased alive on <i>12-28-1966</i> , and that death occurred at <i>3 p.m.</i> M, from the causes and on the date stated above.				22a. SIGNATURE <i>Robert J. Thomas</i>									
22b. DATE SIGNED <i>13/18/66</i>				ATTENDING M.D. <input checked="" type="checkbox"/> PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) Dr. Robt. J. Thomas				22d. ADDRESS 812 Tell House Ave.- Frederick-Md. 21701									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-31-1966	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Md. 21701							
24. FUNERAL DIRECTOR M.R. Etchison & Son				ADDRESS <i>Frederick, Md. 21701</i>	25a. REC'D BY REGISTRAR DATE JAN 3 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17177

CERTIFICATE OF DEATH

17169

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Route #1 Mt. Airy</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Stella</i>	Middle <i>Mae</i>	Last <i>Routzahn</i>	4. DATE OF DEATH Month <i>December</i>	Day Year <i>3 1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-26-12</i>	9. AGE (In years Just birthday) <i>54 yrs.</i>
10a. US/AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Frederick Co., Maryland</i>	
13. FATHER'S NAME <i>John Oscar Green</i>		14. MOTHER'S MAIDEN NAME <i>Dolly Hurd</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs. Lorraine Bowser</i> <i>Route #1 Mount Airy</i>	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>587.0</i>					
DUE TO (b) <i>Acute Diffuse Peritonitis</i>					
DUE TO (c) <i>Acute Hemorrhagic Pancreatitis</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11-30-66</i> , to <i>12-3-1966</i> that (I) (we) last saw the deceased alive on <i>12-3-1966</i> , and that death occurred at <i>10:10 AM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>G F Meadows</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>G F MEADOWS.</i>		22d. ADDRESS <i>Frederick, Maryland.</i>		22e. DATE SIGNED <i>12-3-66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/6/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>E.U.B. Cemetery, Pleasant</i>	
24. FUNERAL DIRECTOR <i>Gladhill Company, Middletown, Maryland.</i>		25d. REC'D BY REGISTRAR <i>W. Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

17178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17170

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 12 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in case of death within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Frederick		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lantz		c. LENGTH OF STAY IN b. 10 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wise Rd. Lantz R. D. 1		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lantz	
f. STREET ADDRESS Wise Rd., Lantz R.D. 1		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ruth		First May	Middle Schlipper
4 DATE OF DEATH Month Dec.	Month 3	Day 1966	Year
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hausenfrau		8b. KIND OF BUSINESS OR INDUSTRY own home	
9a. DATE OF BIRTH June 7, 1907		9b. AGE (In years last birthday) 59 yrs	
10a. BIRTHPLACE (State or foreign country) Maryland		10b. IF UNDER 1 YEAR Months Days Hours Min	
11. MOTHER'S MAIDEN NAME Virginia Noel		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph B. McAllister		14. Address Baltimore, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, No, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Mr. Wilmer H. Schlipper		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Self inflicted gun shot wound Rt. Temple DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 976X (b) DUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 12/13/66			
23a. BURIAL CREMATION, REMOVAL (Specify) Funeral Dec. 6, 1966		23b. DATE THEREOF Dec. 6, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		23d. LOCATION (City or Town) Baltimore, Md.	
24. FUNERAL DIRECTOR Walter G. Grove		25a. ADDRESS Waynesboro, Pa.	
25b. REC'D BY REGISTRAR Charles Judge		25c. DATE DEC 7 1966	
VR A15ME (6M 1/66)			

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17179

CERTIFICATE OF DEATH

17171

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transt permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment.

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Creagerstown	c. LENGTH OF STAY IN 16 Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Creagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d. STREET ADDRESS Thurmont RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SUSAN	Middle CORNELIA	Last SHORB
4. DATE OF DEATH	Month Dec. 13	Day 19	Year 66
S. SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 15, 1884	9. AGE (In years last birthday) 82 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Levi Baltzell	14. MOTHER'S MAIDEN NAME Mary Sheid		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No	16. SOCIAL SECURITY NO 219-54-0898	17. INFORMANT Charles A. Shorb	Address Creagerstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive failure</i>		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
41d1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) <i>atherosclerotic cardio vascular disease</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH many years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1957, to <u>Dec. 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 11, 1966</u> , and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <i>E.A. Dettbarn</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) E.A. DETTBARN	22d. ADDRESS <i>Wollesville, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-17-66	23c. NAME OF CEMETERY OR CREMATORIAL United Brethren Cem.	23d. LOCATION (City or Town) Thurmont
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	25a. REC'D. BY REGISTRAR DEC 19 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17180

17172

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Days		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Union Bridge	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Route 2, Union Bridge e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle JAMES	Last SIMMONS
4. DATE OF DEATH DECEMBER 5 1966	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1898 9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Poolesville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Webster Simmons		14. MOTHER'S MAIDEN NAME Lillie Mae Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. # 1 216 44 6881 17. INFORMANT Mrs. Mary Simmons (Same as item #2) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] CARCINOMA OF THE RECTUM WITH METASTASES TO THE LIVER AND PERIAORTIC NODES			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (1) this hospital attended the deceased from 11/8 1966 , to 12/5 1966 , that (2) we last saw the deceased alive on 12/5 1966 , and that death occurred at 9:27 AM , from the causes and on the date stated above.		22b. DATE SIGNED 12/5/66	
22a. SIGNATURE Richard C. Reynolds,		22b. ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Toll House Ave. Frederick, Maryland	
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Dec 9, 1966 23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery 23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Donald M. Address		25a. REC'D BY REGISTRAR H. R. Hitchison & Son, Frederick, Maryland 25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20M 1/65		DATE DEC 8 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17173

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

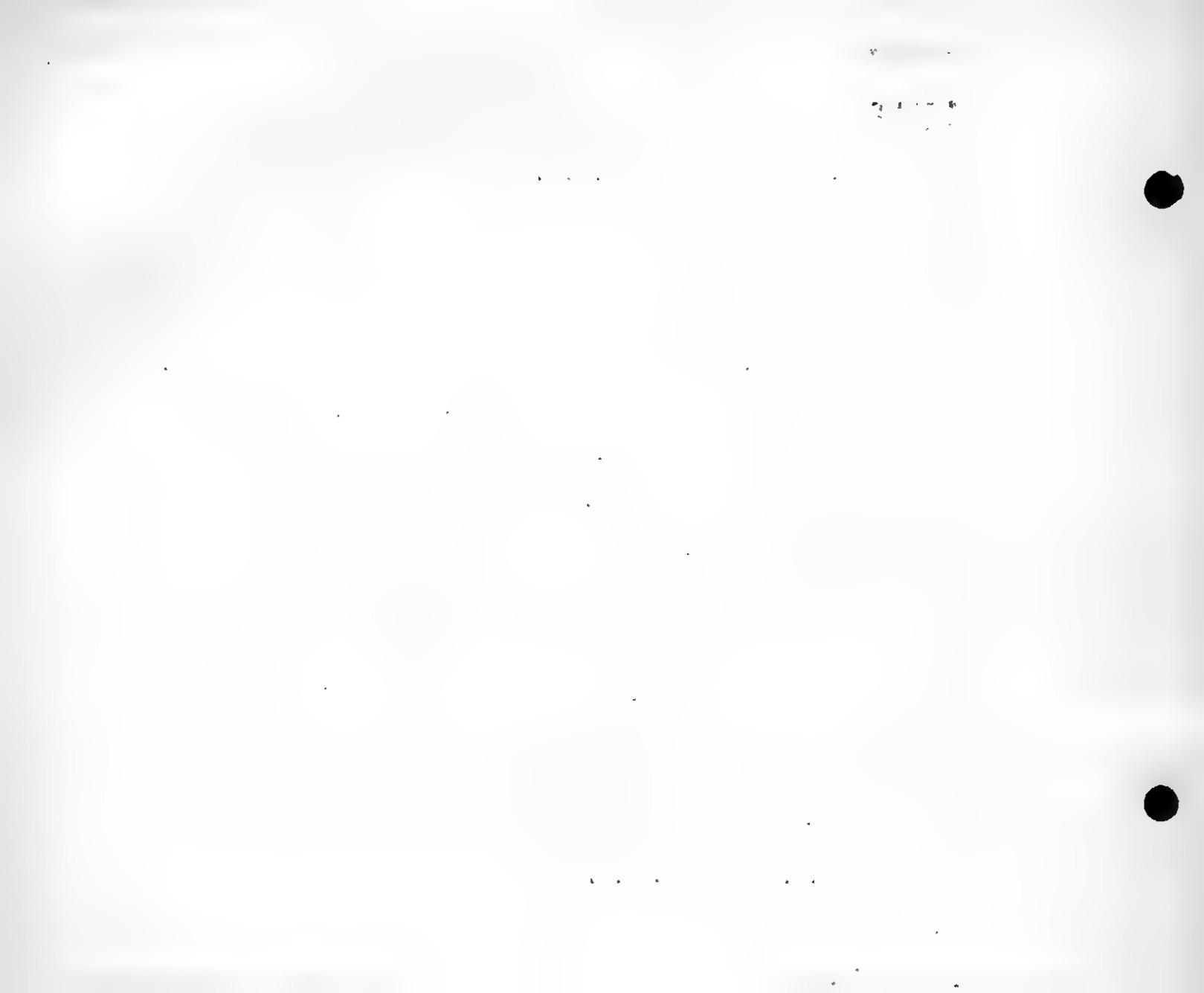
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17181

1 PLACE OF DEATH a. COUNTY Frederick		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb D.C.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick City Hospital		d. STREET ADDRESS 15 Devonshire	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print)	First WILLIAM	Middle HENRY	Last SMITH Sr
4 DATE OF DEATH Dec 1 1966	Month Dec	Day 1	Year 1966
5. SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED	8 DATE OF BIRTH Feb 20 1862
9. AGE (In years last birthday) 53 yrs	10. KIND OF BUSINESS OR INDUSTRY Construction Supt	11. BIRTHPLACE (State or foreign country) Hagerstown MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Truman P. Smith	14. MOTHER'S MAIDEN NAME Beatrice Cullinan	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean	
16. SOCIAL SECURITY NO 131-12-1234		17. INFORMANT Mrs Beatrice Smith	Address 15 Devonshire
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816.1 Conditions, injury which gave rise to immediate cause (a), stating the underlying cause lost		n INTERVAL BETWEEN ONSET AND DEATH Congestive Heart Failure	
DUE TO (b) Massive Subdural Hemorrhage			
DUE TO (c) Fractured Skull			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Truck-Auto collision			
20c. TIME OF INJURY Month, Day, Year 6 p.m. 12-3-66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or Town) Point of Rocks - Frederick Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O.Thomas</i>	MD	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O.Thomas, Sr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) urn		23b. DATE THEREOF 12/7/66	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery
24. FUNERAL DIRECTOR Andrew K. Coffin Funeral Home Inc		23d. LOCATION (City or Town) Hagerstown	(County) (State)
		25a. REC'D. BY REGISTRAR DATE DEC 3 1966	25b. REGISTRAR'S SIGNATURE <i>John J. Coffin</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17182

CERTIFICATE OF DEATH

17174

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Frederick		b. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Frederick		9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
Frederick Memorial Hosp. 101		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last
JOHN	FRANKLIN	SNEED	4. DATE OF DEATH
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
MALE	W/	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/15/97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Engineer-Burr (Ret.)		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Jim Sneed		Tenn. USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		403-07-080 John F. Sneed Jr Brunswick Md.	
Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA</u>			
162.1 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from 11/30, 1966, to 12/10/66, 19_____, that (I) we last saw the deceased alive on 12/19 1966, and that death occurred at 1 PM, from the causes and on the date stated above.			
22a. SIGNATURE			
Richard C. Reynolds		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Richard C. Reynolds, MD		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		12/14/66	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)	
Arlington National		Fort Myer Virginia	
24. FUNERAL DIRECTOR		ADDRESS	
Feele Funeral Home		Brunswick Maryland	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE DEC 13 1966		Charles Judge	



FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

VR A15ME (5)
6M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17183

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17175

1 PLACE OF DEATH a. COUNTY Frederick			2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Frederick		c. LENGTH OF STAY IN TB Years		c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS 411 Delaware Read		
e. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)	First Roscoe	Middle Conklin	Lost	4 DATE OF DEATH Month December	Day Year 28- 19 66
S SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Sept. 28-1881	9 AGE (in years last birthday) 85 yrs
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY City Park Dept.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Jacob Hansen Spurrier			14. MOTHER'S MAIDEN NAME Mary Burton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 212-24-5190A		17. INFORMANT Mr. W.M.Ray Spurrier-411 Delaware Rd.	
Address Frederick, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 570.5 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Intestinal Obstruction- Ileus DUE TO (c) Fractured Hip					
INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>B.O.Thomas</u> MD					
EXAMINER'S NAME (Type) B.O.Thomas					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-30-1966	23c. NAME OF CEMETERY OR CREMATORIAL Frederick Mem. Park	23d. LOCATION (City or Town) (County) (State) W. of Frederick, Md. 21701		
24. FUNERAL DIRECTOR M.R.Etchisen & Son	ADDRESS Whitmore	25a. DECD BY REG STAR DEC 30 1966	25b. REGISTRAR'S SIGNATURE Judge		

42

FOR STATE
HEALTH DEPT.

17184

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Frederick County

MARYLAND

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

RFID#2 Taneytown

c. LENGTH OF STAY IN lb

15 minutes

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Clayton Sylvester Staub

2. USUAL RESIDENCE (Where deceased lived, if not in town: Residence before admission)
a. STATE

Maryland

b. COUNTY Carroll

3. NAME OF
DECEASED
(Type or print)

Clayton Sylvester

Staub

DATE
OF
DEATH

Dec. 25

Day
Year
19 66

4. SEX

Male

W

5. COLOR OR RACE

7. MARRIED

WIDOWED

★

DIVORCED

8. DATE OF BIRTH

NEVER MARRIED

□

□

□

□

9. AGE (In years
last birthday)

62 yrs

10. BIRTHPLACE (State or foreign country)

Frederick Co., Md.

11. CITIZEN OF WHAT
COUNTRY?

U.S.A.

6. Do USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR
INDUSTRY

Farm

12. FATHER'S NAME

Roy C. Staub

13. MOTHER'S MAIDEN NAME

Mary S. Fogle

14. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of serv ce)

No

15. SOCIAL SECURITY NO

216-10-0354

16. INFORMANT

Robert C. Staub

Address

R. D. 3, Emmitsburg, Md.

17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY-

IMMEDIATE CAUSE (a)

420.1

DUE TO

(b)

DUE TO

(c)

Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.

Coronary thromboses

Arterio-sclerotic C.V.D.

2. 10 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

19

20d. INJURY OCCURRED

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opiniondeath resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22. DATE SIGNED

Richard A. Little

ADDRESS

Littlestown, Pa.

DATE

DEC 26 1966

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

12/28/66

23c. NAME OF CEMETERY OR CREMATORI

Lutheran Cemetery

23d. LOCATION (City or Town) (County) (State)

Taneytown, Carroll Co., Md.

23e. REG'D BY, REGISTRAR

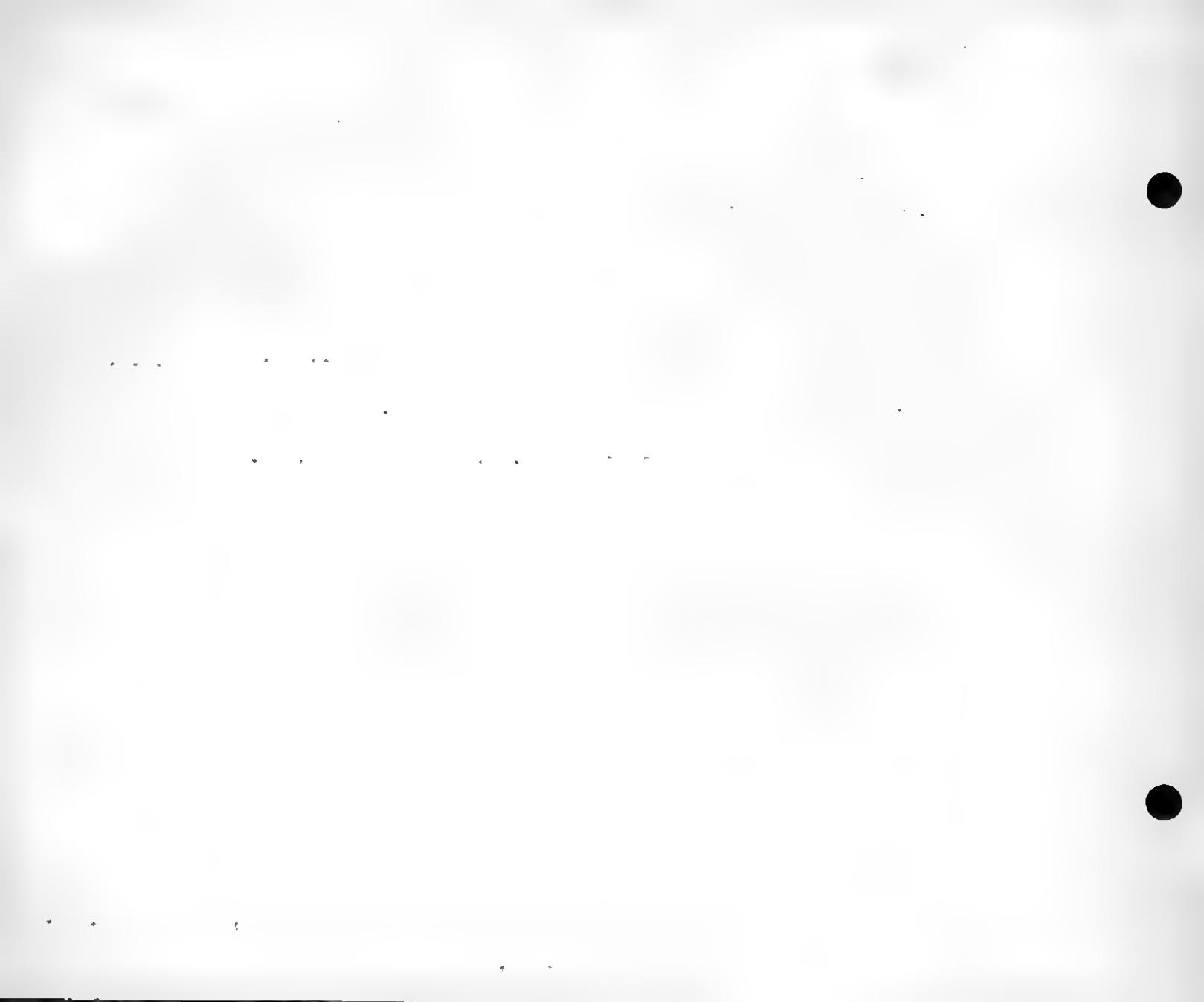
Date

DEC 26 1966

23f. REGISTRAR'S SIGNATURE

James Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. File pages 1 and 2 with the State Department of Health. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

certificate be executed within 24 hours after death.

The law requires that the attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) II West 1C Street		d. STREET ADDRESS same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CATHERINE	Middle REBECCA	Last STINE	4. DATE OF DEATH Month 12 Day 9 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19/1883	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME GEORGE WATTS		14. MOTHER'S MAIDEN NAME MARY E. KELLER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Mary Edna LaPole Baltimore Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) <i>steroids</i>		INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/1/66</u> , 19 <u>66</u> , to <u>12/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/5/66</u> , 19 <u>66</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <i>J.G.F. Smith</i>		22b. DATE SIGNED 12/19/66			
22c. PHYSICIAN'S NAME (Type) J.G.F. Smith, M.D.		22d. ADDRESS Brunswick Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/11/66	23c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery	23d. LOCATION (City, town or county) Huddertown Maryland		
24. FUNERAL DIRECTOR Fleete Funeral Home	ADDRESS Brunswick Maryland	25a. REC'D BY REGISTRAR DEC 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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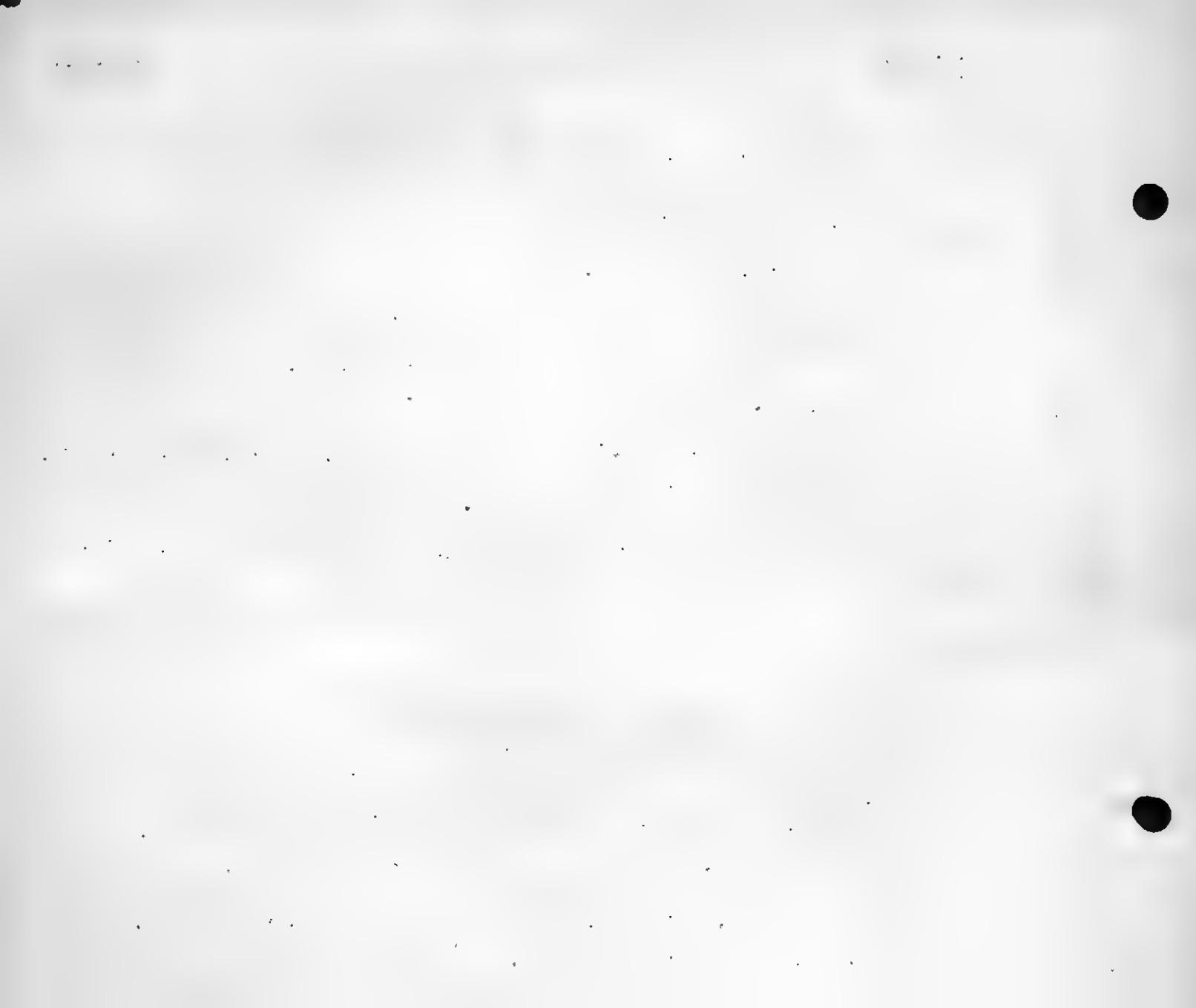
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17186

CERTIFICATE OF DEATH

17178

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN lb 19 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia 19.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue County Home 94		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Harry	Middle M.	Last Thompson
4. DATE OF DEATH	Month Dec. 21	Day 19	Year 66
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 6, 1888
			9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Monrovia, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Thompson		14. MOTHER'S MAIDEN NAME Frances Cook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-14-6273T 17. INFORMANT Address Mrs Nannie Browning, Monrovia, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure DUE TO conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis cardio vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1966 to Dec 21, 1966, that (I) (we) last saw the deceased alive on Dec 21, 1966, and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE LeRoy T Davis		22b. DATE SIGNED 12/21/66	
22c. PHYSICIAN'S NAME (Type) LeRoy T. Davis		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1966 23c. NAME OF CEMETERY OR CREMATORIAL Providence Meth.	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		23d. LOCATION (City, town or county) (State) Kempton, Md.	
		25a. REC'D BY REGISTRAR DEC 28 1966	25b. REGISTRAR'S SIGNATURE James Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17187

CERTIFICATE OF DEATH

17179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Myersville		d. STREET ADDRESS RD 2				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Nellie	Middle Grace	Last Toms	4. DATE OF DEATH Dec. 5 1966	Month Year	Day	Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-1884	9. AGE (in years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME James Linton		14. MOTHER'S MAIDEN NAME Amanda Lewis		Address						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Roy Green		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1 (b) atherosclerotic heart disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 1 hour		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov 19 1966 , to Dec 5 1966 , that (I) (we) last saw the deceased alive on Dec 5 1966 , and that death occurred at 7 PM , from the causes and on the date stated above.		22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 5 Dec '66						
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 84 Toll House Ave Frederick, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-8-66		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Bethel Cemetery	23d. LOCATION (City, town or county) Mr. Foxville Fred. Co	(State)
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR DEC 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #1c & 22c Film 12/15/66 pg

17188

CERTIFICATE OF DEATH

17180

1. PLACE OF DEATH a. COUNTY Frederick Maryland		2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg,		c. LENGTH OF STAY IN lb 30 20 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg			
d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address)		d. STREET ADDRESS R.D. # 1				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Margaret Janson Wasilifsky		First Margaret	Middle Janson			
4. DATE OF DEATH December 2, 1966	5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Aug. 24, 1906	9. AGE (In years last birthday) 60 yrs	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME James H. Schmidt	14. MOTHER'S MAIDEN NAME Margaret Janson	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 215-36-6134	17. INFORMANT Adolph Wasilifsky, Emmitsburg, Md. R.D. #1	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerotic heart disease (b) DUE TO (c)	19. WAS ANATOMICAL EXAMINATION PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			21. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Emmitsburg, Md.	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from April 14, 1961 , to Nov 28, 1966 that (1) (we) last saw the deceased alive on Nov 28, 1966 , and that death occurred at 6 A.M. , from causes and on the date stated above.	22a. SIGNATURE George P. Morinigstar		22b. DATE SIGNED Dec. 3, 66			
22c. PHYSICIAN'S NAME (Type) Dr. George P. Morinigstar	22d. ADDRESS Emmitsburg, Md.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 6, 1966	23c. NAME OF CEMETERY OR CREMATORIAL St. Anthony's Shrine	23d. LOCATION (City or Town) (County) (State) Emmitsburg, Frederick Co. Md.			
24. FUNERAL DIRECTOR Clarence E. Wilson	25a. REC'D BY REGISTRAR DEC 5 1966	25b. REGISTRAR'S SIGNATURE Clarence E. Wilson				
VR A15 (4) 20 M 1/66						



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

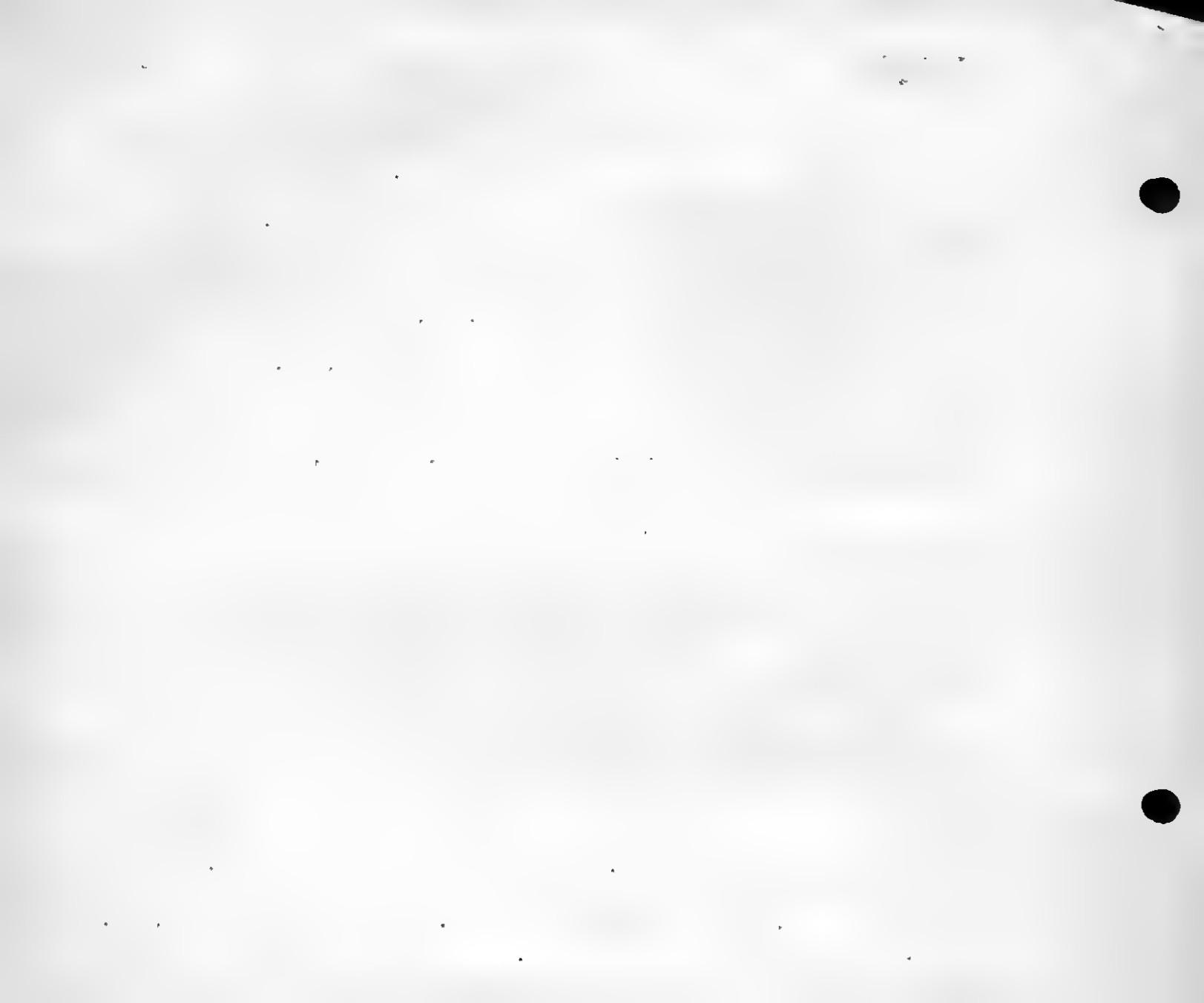
17189

CERTIFICATE OF DEATH

17181

10 HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transt permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with n/72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll ✓	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, wrte RURAL and give nearest town) Mt. Airy			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita., give street address) Frederick Nursing Center		d. STREET ADDRESS 806 Park Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mrs. Selma V.	Middle Watkins	Last	4. DATE OF DEATH Dec. 26 1966	Month	Doy	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	B. DATE OF BIRTH Jan. 17, 1893	9. AGE (in years last birthday) 73 yrs	10. UNDER 1 YEAR Months	11. UNDER 24 HRS Days Hours Min
10a. US LABOR OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eldridge Mullinix		14. MOTHER'S MAIDEN NAME Rozena Merson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-28-5668		17. INFORMANT Rudy E. Watkins, Item 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0		DUE TO (b) Severe Arteriosclerotic Heart Disease 6 mo		Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from July 1, 1966, to Dec. 26, 1966, that (I) (we) last saw the deceased alive on Dec. 26, 1966, and that death occurred at 7 AM, from causes and on the date stated above.							
22a. SIGNATURE G. A. Pearre, Sr.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/26/66	
22c. PHYSICIAN'S NAME (Type) A. A. Pearre, Sr.		22d. ADDRESS Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 29, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Montgomery Meth.		23d. LOCATION (City or Town) (County) (State) Clagettsville, Md.		
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS	25a. REC'D BY REGISTRAR DEC 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

17190

17182

1. PLACE OF DEATH

a. COUNTY

FREDERICK

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

WOODSBORO

c. LENGTH OF STAY IN TB

YEARS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

RURAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

DATE
OF
DEATH

Month

Dey

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)
DUE TO
AXILLARY, INGUINAL & mesenteric NODES

(c)
WITH METASTASES TO SPINE, CERVICAL, PREAURICULAR

LYMPHOSARCOMA, LEFT EPITROCHLEAR LYMPHNODE

MD
INTERVAL BETWEEN
ONSET AND DEATH
3 YEARS

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED?

SEVERE SECONDARY PANCYTOPENIA RESULTANT FROM TUMOR + URACIL YES NO

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b)
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour a.m.
p.m.

While at work Not While at work

21. I certify that (I) (this hospital) attended the deceased from SEPT 19 64 to 12/3 19 66 that (I) (we) last saw the deceased alive on 12/2 19 66, and that death occurred at 2:30 PM, from the causes and on the date stated above.

22e. SIGNATURE

JAMES E. STONER, JR. M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
12/3/66

22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS

WALKERSVILLE MD

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM 23d. LOCATION (City, town or county) (State)

BURIAL 12-6-66 MT. HOPE CEM. WOODSBORO, MD

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

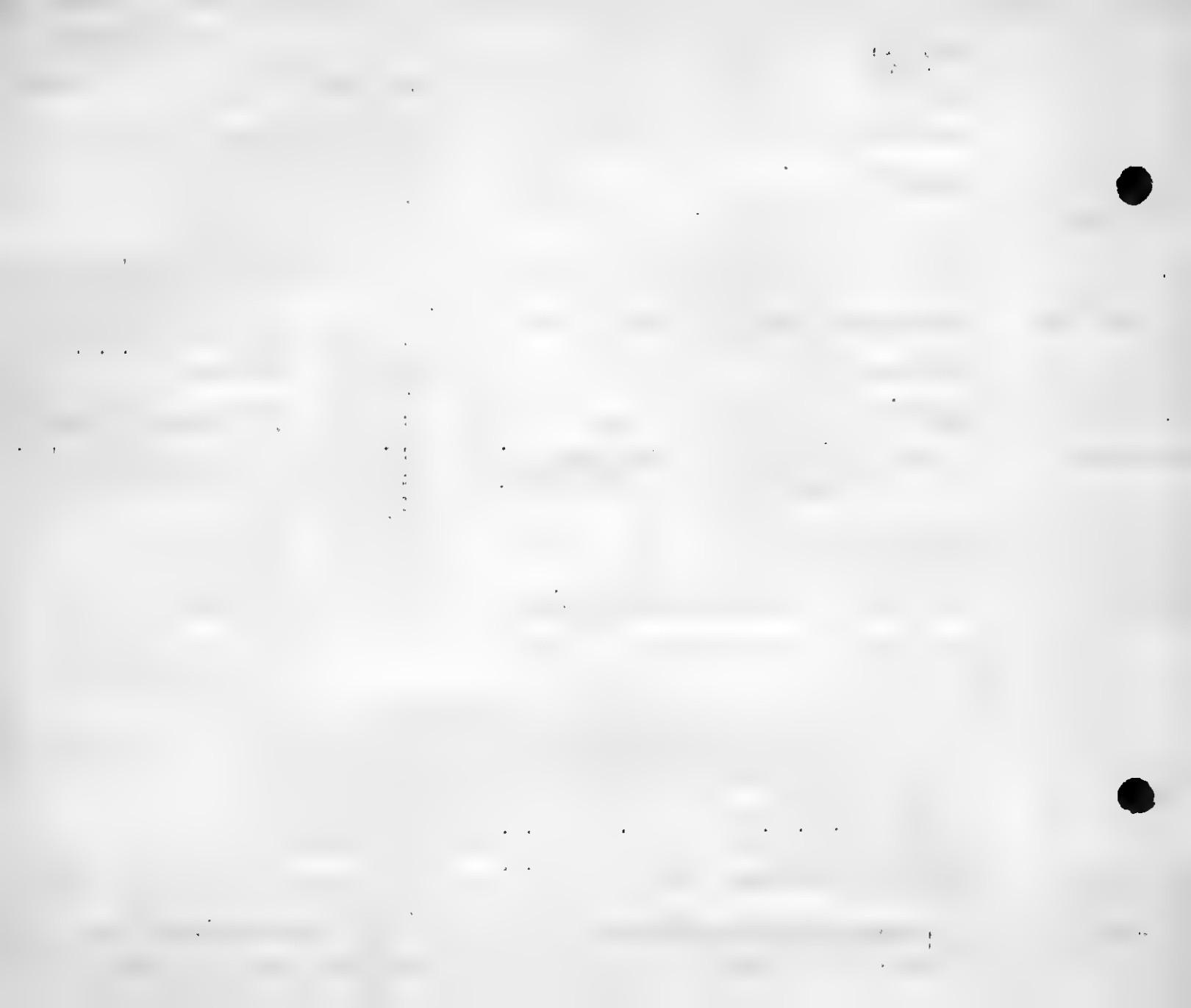
Powell & Hartley Woodsboro, MD DATE DEC 7 1966 Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
17191												17183											
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)																				
a. COUNTY Frederick			a. STATE Maryland																				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Rt. # 340			b. COUNTY Frederick																				
c. LENGTH OF STAY IN lb			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Frederick																				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DOA Frederick Memorial Hospital			d. STREET ADDRESS Route # 4			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) LEE ALBERT WHIPP			4. DATE OF DEATH December 18, 1966																				
First		Middle	Last	Month	Day	Year																	
5. SEX Male			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1942		9. AGE (in years at last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.												
WIDOWED <input type="checkbox"/>			DIVORCED <input type="checkbox"/>																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Construction			11. BIRTHPLACE (State or foreign country) Frederick County, Maryland			12. CITIZEN OF WHAT COUNTRY U.S.A.														
13. FATHER'S NAME Harry R. Whipp			14. MOTHER'S MAIDEN NAME Naomi Wirtz																				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 216-38-0377			17. INFORMANT Mrs. Gloria B. Whipp			Address Route # 4 Frederick, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 825.4																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)			Subdural & Subarachnoid Hemorrhage																				
} DUE TO (c)			Fractured Skull																				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e).												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident																				
20c. TIME OF INJURY Month, Day, Year 6:30 p.m. 12-18-1966			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway			20f. (City or town) Frederick - Frederick Md.														
									(County)														
									(State)														
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Dr. B. O. Thomas, Sr. M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 12-18-66														
EXAMINER'S NAME (Type) DR. B. O. THOMAS, SR. M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county)																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12-21-1966			22c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery			22d. LOCATION (City, town, or county) Frederick Co. Maryland														
									(State)														
23. FUNERAL DIRECTOR Robert E. Dalley & Son			ADDRESS			24a. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE														
			Frederick, Maryland																				
						DATE 12-23-1966			Signature														
VR A15ME 5M 1/63																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17192

17184

1. PLACE OF DEATH

a. COUNTY

Frederick

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN IB

Month

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Montevue Infirmary

MARYLAND

**3. NAME OF DECEASED
(Type or pr. n.l.)**

ANNA

Middle

BELLE

5. SEX

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

Female

DIVORCED

Feb. 2, 1879

WIDOWED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Henry Stout

14. MOTHER'S MAIDEN NAME

Anna Bates

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

219 54 2330 Montevue Infirmary Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY;

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Gastrointestinal hemorrhage
Chronic gastritis

INTERVAL BETWEEN
ONSET AND DEATH
2 days

2 years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1966 to Dec. 30, 1966, that (I) (we) last saw the deceased alive on Dec. 30, 1966, and that death occurred at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE

Leroy T. Davis

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

Dec. 31, 1966

22c. PHYSICIAN'S
NAME (Type)

Leroy T. Davis, M. D.

22d. ADDRESS

228 N. Market Street, Frederick, Md

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

Jan. 3, 1967

Union Cemetery,

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

Lovettsville, Va.

24 FUNERAL DIRECTOR'S SIGNATURE

Frank R. Smith Jr.

M. R. Etchison & Son, Frederick, Maryland

ADDRESS

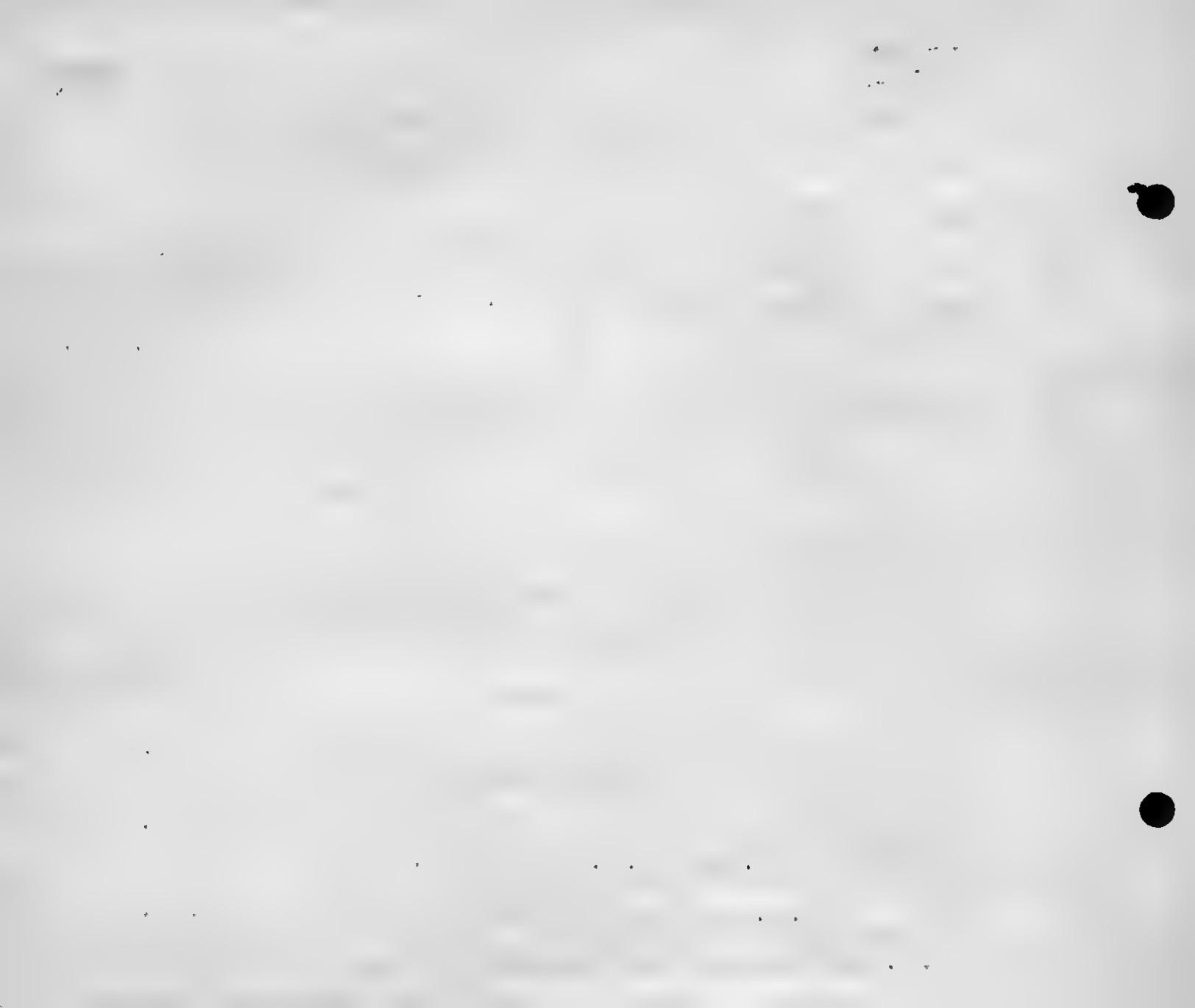
25a. REC'D BY REGISTRAR

JAN 3 1967

1966

25b. REGISTRAR'S SIGNATURE

J. L. Jude



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

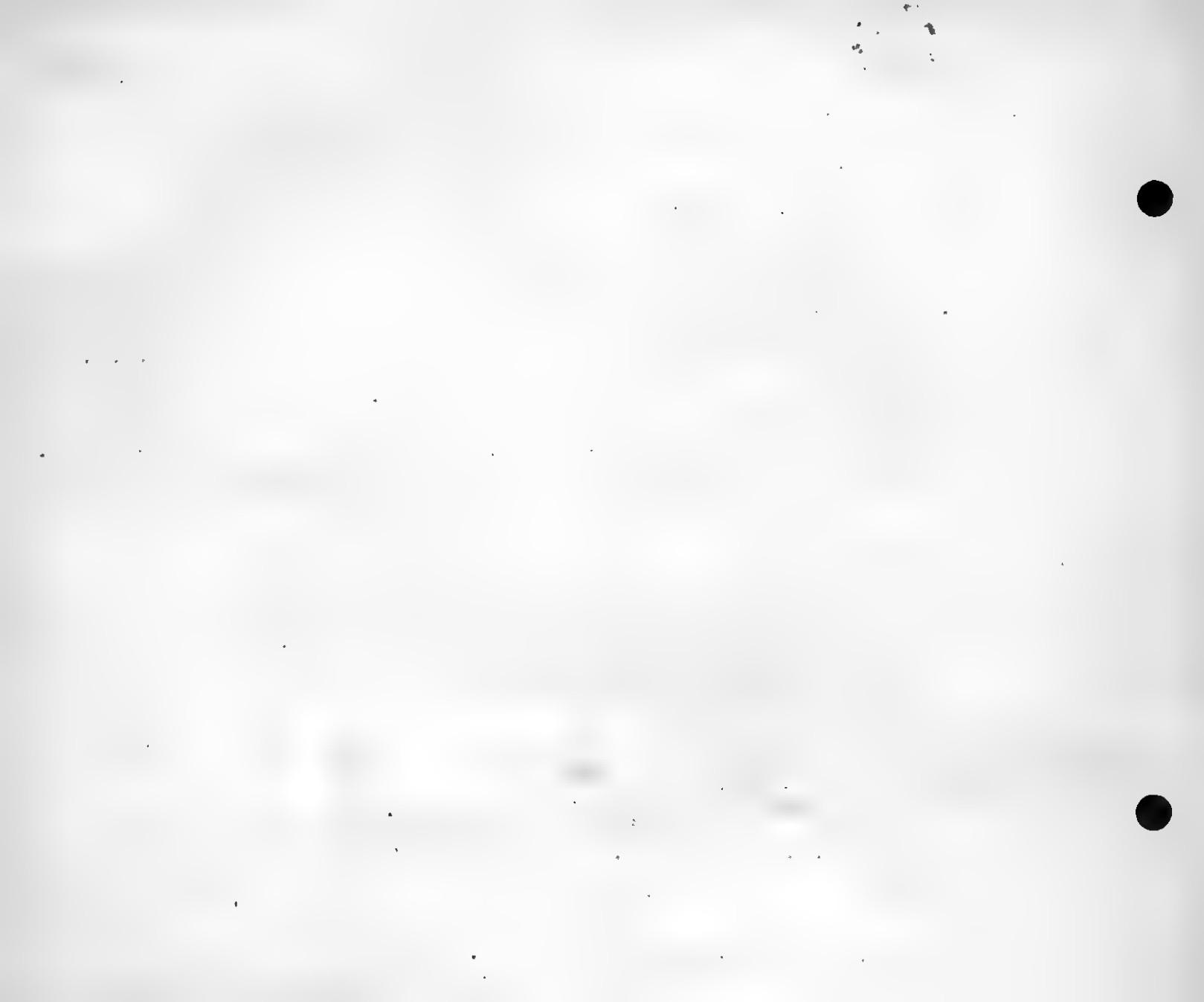
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17193

CERTIFICATE OF DEATH

17185

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland b. COUNTY		Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Brunswick		c. LENGTH OF STAY IN 1B		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		I05 West 1C ¹ Street		d. STREET ADDRESS		Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
HENRY NELSON YATES					12	2	1966		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS		
M.		W.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/II/1892	74 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired engineer		B&O Railroad		Virginia		U.S.A.			
13. FATHER'S NAME		unknown		14. MOTHER'S MAIDEN NAME		unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		705-10-2551		Robert O. Decker		Brunswick Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Disease</i> 10 days									
151X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) this hospital attended the deceased from 2/19/66 to 2/21/1966 that (I) we last saw the deceased alive on 19/66 and that death occurred at 7A.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>J.G.F. Smith, M.D.</i>									
22b. DATE SIGNED 12/18/66									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Brunswick Maryland							
Burial, Cremation, Removal (Specify)		DATE THEREOF 12/4/66		NAME OF CEMETERY OR CREMATORIUM Mount Carmel Cemetery		LOCATION (City, town or county) Middletown (State) Virginia			
24. FUNERAL DIRECTOR		ADDRESS Brunswick Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Fulte Funeral Home				DATE DEC 5 1966		James J. ...			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
No HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**2**
Page 4 may be retained by the hospital or attending physician.
3
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17194

CERTIFICATE OF DEATH

17186

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		d. STREET ADDRESS N. Carroll St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Florence Daisy Zentz		First	Middle	Last	4. DATE OF DEATH Dec. 21	Month	Day	Year 1966
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1872	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Catherine Harbaugh						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Albert Zentz		Address Thurmont, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Virus infection		INTERVAL BETWEEN ONSET AND DEATH 3 days				
492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO		7 days				
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that (I) (this hospital) attended the deceased from Dec 14, 1966, to Dec 21, 1966, that (I) (we) last saw the deceased alive on Dec. 20 1966, and that death occurred at 10A.M. from causes and on the date stated above.								
22a. SIGNATURE James K. Gray		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-24-66		23c. NAME OF CEMETERY OR CREMATORIAL United Brethren Cem.		23d. LOCATION (City or Town) Thurmont Fred. Co. Md.		(County) (State)
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR DEC 27 1966		25b. REGISTRAR'S SIGNATURE Florence Judge		
Raymond E. Creager								

38151

10151

**FOR STATE
HEALTH DEPT.**

I
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 6 Film G385 12/14/66 mh

17195

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17187

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN lb Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 10.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 313 1/2 West South Street		d. STREET ADDRESS 312 1/2 West South Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle A.	Last ZIMMERMAN, Jr.
4. DATE OF DEATH Month December	Day 5	Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 1912 10. BIRTHPLACE (State or foreign country) Frederick, Maryland
9. AGE (In years lost birthday) 54 yrs.	10. BIRTHPLACE (State or foreign country) Frederick, Maryland	11. CITIZEN OF WHAT COUNTRY? U. S. A.	12. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Arlans Dept. Store	
13. FATHER'S NAME William A. Zimmerman, Sr.		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. W. W. # 2	17. INFORMANT William A. Zimmerman, 3rd. Frederick, Maryland	18. ADDRESS W. Patrick St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 4200		DUE TO (b) Arteriosclerotic Heart Disease	
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O.Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 12-5-66	
EXAMINER'S NAME (Type) B.O. Thomas, Sr. M.D.		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 8, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery	23d. LOCATION (City or Town) (County) (State) Fort Myers, Va.
24. FUNERAL DIRECTOR Houseal M. Etchison	ADDRESS Fidelity	25a. RECD BY REGISTRAR DATE DEC 8 1966	25b. REGISTRAR'S SIGNATURE J Charles Judge
M. R. Etchison & Son, Frederick, Maryland			

4451

4452